

Chapter 17

MANAGEMENT OF RECRUIT SUICIDE

ANTHONY L. COX, MSW^{*}; DONNA L. EDISON, DO[†]; ROBERT L. STEWART, PhD[‡]; CARRIE DORSON, PhD[§]; AND
ELSPETH CAMERON RITCHIE, MD, MPH[¶]

INTRODUCTION

STRESS IN MILITARY TRAINING

SUICIDE STATISTICS

- Military and Recruit Suicide Statistics
- Problems with Suicide Statistics

RISK FACTORS AND VULNERABLE INDIVIDUALS

- Military-Specific Risk
- Recruit-Specific Risk
- Research on Risk
- Risk Prediction Models
- Protective Factors
- Suicide Contagion and Epidemics

RISK ASSESSMENT PROCEDURES

- Echelons of Care
- Trust and Rapport
- Systematic Assessment
- Models of Assessment and Assignment of Risk Category
- Methodology: Elements of Suicide Risk Assessment

MANAGEMENT OF SUICIDAL RECRUITS

- Management According to Level of Risk
- Management Plans and Strategies
- Staff Burnout and Mistakes

PREVENTION OF RECRUIT SUICIDE

HELPING SURVIVORS (POSTVENTION)

SUMMARY

ATTACHMENT: RISK-MANAGEMENT FLOWCHARTS

^{*} Lieutenant Colonel, Medical Corps, US Army, Walter Reed Army Institute of Research, Bldg 503, Rm 2W-85, 503 Robert Grant Avenue, Silver Spring, Maryland 20910

[†] Senior Child Psychiatrist, Walter Reed Army Medical Center; Assistant Professor of Psychiatry, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

[‡] Colonel, Medical Service Corps, US Army; Chief, Behavioral Health, Dewitt Army Community Hospital, Fort Belvoir, Virginia 20060

[§] Formerly, Captain, US Air Force; Assistant Chief, Clinical Psychologist, Brooke Army Medical Center, 5239 Eisenhower Road, #2424, San Antonio, Texas 78218

[¶] Colonel, Medical Corps, US Army; Associate Professor of Psychiatry, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

INTRODUCTION

One Army training base's outpatient mental health clinic sees an average of five recruits expressing suicidal intent each day.

Completed suicide in the recruit population is extremely rare, but suicidal ideation in the recruit population is common.^{1,2} Patients who present with suicidal thoughts or behaviors make medical and behavioral health personnel uncomfortable. In addition to the personal discomfort many feel about suicide and suicidal behaviors, there are professional risks involved in working with suicidal patients.³ Farberow noted:

When a suicide of a patient occurs, it generally brings with it severe emotional impact; reputation and career-affecting implications; financial and professional complications; unfamiliar legal involvement; and the stress of clinician-survivor bereavement. Even with the best of care it is impossible to predict or prevent all suicides.^{3(pviii)}

Despite an immense accumulation of historical, theoretical, and research literature, experts do not precisely understand the specific factors and pathways culminating in completed suicide. Experts do agree that suicidality is a highly complex biopsychosocial event with multiple interacting determinants. This complexity and lack of prognostic precision, combined with the burdensome responsibility for outcomes, result in distress for medical and behavioral health specialists.³⁻⁵

Working with military recruits heightens these discomforts and difficulties. Recruits are much more likely to experience suicidal ideation due to acute stress or homesickness. Those who wish to leave the military (or at least avoid the rigor of the training environment) may use a confession of suicidal ideation as a “get-out-of-the-military-free card.” The military medical or behavioral health provider feels pressure to decide—correctly each and every time—whether the recruit is suicidal or malingering. In addition, military medical providers must struggle with their dual mandate to consider the best interest of the recruit and the military.⁶

Although the strain on providers working with military recruits may be great and the numbers of recruits with suicidal ideation high, the extremely low rate of completed suicide among military recruits⁷ confirms that protective factors inherent in the modern military training environment exist and succeed.

The risk factors, protective factors, pressures on practitioners, and other environmental aspects make suicide assessment in the recruit training environment a unique challenge to those seeking to intervene in positive ways. The purpose of this chapter is to provide medical and behavioral health professionals working with recruits a standard of risk assessment and management that relies on awareness of uncertainties, tolerance of ambiguity, respect for a systematic perspective, and good judgment. This standard will help shift the focus away from diagnosis and toward treatment. It is *not* a cookbook approach; rather, the standard recognizes that each suicidal recruit presents with a unique risk profile. The assessment and management recommended here involves a probabilistic calculation of risk both to the recruit and to the military.

Why bother with such a difficult and ambiguous task? There are, at least, two reasons: (1) to reduce the anxiety providers experience while assessing and managing suicidal recruits, and (2) to change the way providers approach the assessment and management of recruit suicidal ideation and behavior. How providers and stressed recruits interact will have long-term consequences for the providers, the recruits, and the military. Attitudes about these issues are at least as important as actions taken.

To accomplish these goals, this chapter will address these common questions:

- How do I know who is faking?
- How do I know who might actually kill themselves? How do I help prevent it?
- What do I do with everyone in between?
 - Who might be an okay soldier? How do I help them become one?
 - Who won't make it in the military? What do I do with them?
- If I pay too much attention to “whining” trainees, will it start an epidemic? If I send them home, will that start an epidemic?
- Whose side am I on, the recruit's or the command's?
- Where do I get help with making these decisions?

The goal of military training continues to be selection of those who are motivated and fit to serve. The corollary is deselection of those who are not fit and not motivated to serve.

STRESS IN MILITARY TRAINING

Military training is designed to be inherently difficult for several reasons. First, training is used as a screening tool. U'Ren, in his study of mental health issues among cadets at the US Military Academy at West Point, New York, noted that, "[t]he system is designed to maintain a delicate balance between forcing out those who are unmotivated or incapable of withstanding the rigors of military life and incorporating those who are fit. The ordeal must be difficult, but not impossible; the resignation rate must not be too high. If all goes well, this experience increases group cohesion and identity for most. Survivors of the process have a shared experience; they have proved themselves in a difficult situation."^{2(p185)}

Second, the rigor of initial military training and the constant focus on group cohesion reduces individualism and builds a team mentality. This sense of teamwork and loyalty to group identity creates a distinct community. Indeed, "[t]here is no comparable population of civilians that shares with soldiers [a] history as young professionals 'employed' in a total institution who have selected themselves to exceed minimum mental competency levels; to participate in an ongoing regimen of physical conditioning; and to be inoculated, fed, clothed, housed, and provided with mandatory comprehensive health care. These attributes, as well as the norms, traditions, and other shared aspects of the life of a soldier, allows us to consider the US Army as a distinct society."^{8(p120)}

This process is not an easy one. As early as the 1920s, Kerns recognized mental health problems dur-

ing military training: "No system can take a group of young men, dress them alike, teach them alike, drill them alike, and grind them through the same machine, without breaking a few of them. Fortunately, conditions for observation and general supervision of cases could hardly be better. The medical department is the one flexible link in the military chain; the doctor is custodian of the keys that open the door to escape; the hospital is a safety valve....The schedule is so rigorous that the Cadet is only too glad to consult the physician upon the slightest pretext, in the hope that he may be excused from drill or be admitted to the hospital for a few days' rest."^{9(p690)}

Recruits are even more at risk than cadets, since they are in training for only 8 to 13 weeks (compared to cadets' 4 years) and thus have significantly less time to adapt, bond with others, and prove themselves. Despite the focus on team building, peer-to-peer cohesion in a training unit is not well developed. Recruits are new to one another, no emphasis is placed on recruits getting to know each other, the training period is short, and recruits all know they will soon be leaving current relationships behind as they move to permanent assignments around the world. However, those who fail to form bonds are at risk of being stigmatized, becoming depressed, leaving the military, or becoming suicidal. As Kern observed, the military medical system remains an important gatekeeper and support system for military recruits. How this "safety valve" is used makes a difference.

SUICIDE STATISTICS

About 30,000 Americans die from suicide each year, making suicide the ninth leading cause of death in the country.¹⁰ Although the general suicide rate has remained stable at around 11 per 100,000 per year, the rate of suicide among young adults and teens has nearly tripled since 1952.¹⁰ In fact, "more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined."¹⁰

In general, females tend to have higher rates of suicidal ideation and deliberate acts of self-harm.¹¹ Among a sample of 694 college freshmen, Meehan¹² reported that 26% had contemplated suicide in the proceeding 12 months, and the majority of those self-reporting suicide attempts were women. Nevertheless, males complete suicide more often than females in every culture;¹³ among Americans, "males are at

least four times more likely to die from suicide" than females.^{10(p3)} Since the majority of service members are young males, the fact that suicide is the second^{14,15} or third^{16,17} leading cause of noncombat death in the US military should not be surprising.

Military and Recruit Suicide Statistics

Before 1958, rates of suicide within the military were higher than the rates among similar-aged civilians.⁸ Furthermore, the rates of suicide were significantly higher among officers than enlisted personnel.⁸ Gradually, matched-sample suicide rates have reversed: the military now has lower rates of suicide than the civilian population, and enlisted suicide rates are now approximately twice those of officers.¹⁴ Using data from 1980 to 1992, Sentell et al¹⁶ compared suicide

rates between the military and civilian populations. They noted that, adjusted for age, gender, and race differences, military suicide rates were lower than the civilian rates, in some cases by as much as 30% to 40%. The United Kingdom has also found that the military has lower rates of suicide than the civilian population.¹⁸ Although no reasons for this reversal have been proven, one could speculate that today, the military tends to be more conservative and self-restrained in comparison to the current American (or English) culture, while the reverse was true in the late 19th and early 20th centuries.¹⁹ This speculation has been disputed, however.²⁰

Eaton and colleagues,²¹ in their 11-year review of military suicides (1990–2000), noted that the military had a lower crude suicide rate than the overall civilian rate (12.98/100,000 vs 14.15/100,000). Additionally, an even lower military rate of 9.16/100,000 was calculated by adjusting the military sample for age, gender, and race to match the civilian population. Nevertheless, the study noted variations of up to 40% in the annual suicide rates of the various military services, making it difficult to determine whether a rise in rate in any given year constitutes an “outbreak,” or whether a drop in rate constitutes a prevention success.

Prior to Scoville’s⁷ dissertation in 2002, suicide in the US recruit population had not been systematically studied. In her 24-year review of military recruit deaths from 1977–2001, Scoville found 46 suicides completed by recruits (all services) during basic training. Table 17-1 presents the overall suicide rates by service. Eighty percent (37) of these suicides occurred while the recruit was in training status, and 20% (9) occurred while the recruit was hospitalized or awaiting discharge. Adjusting the denominator to account for the duration of training, Scoville found that suicide rates among basic trainees “were 5 and 4 deaths per 100,000 recruit-years from 1977 through 2001 in ages 17–24 and 25+, respectively, which is less than half of those in US civilians.”^{7(p24)} Furthermore, since the 46 deaths (the numerator) include both active and reserve components, while the service populations (the denominator) reflect only the active components, these rates are actually an overestimate of the suicide rates. This overestimate is most pronounced in the Army, where the Army Reserve (20%) and the National Guard (33%) make up more than half of the personnel. If one assumes that the Army’s overestimated rate is 7.3 per 100,000, and that the reserve components make up only 40% of the population, then the actual rate of Army basic training suicides may well be 2.9 per 100,000—about a fourth the rate of suicide in the regular Army.

Partonen²² analyzed 50 Finnish draftee suicides between 1981 and 1990. He noted that the rates were

TABLE 17-1

OVERALL SUICIDE RATES* BY SERVICE, 1977–2001

	n	N	Rate
US Army	28	24.9	7.3
US Navy	6	17.5	2.2
US Air Force	4	11.8	2.9
US Marine Corps	8	8.7	4.3
Total	46	62.9	4.8

*per 100,000 non-prior service active component recruit-years

n: number of recruit suicides

N x 100,000: recruit accessions

Reproduced from: Scoville SL. Mortality during US armed forces basic training: A 25-year review (1977–2001) Uniformed Services University of Health Sciences; 2002.

lower than in age-matched controls, and that the suicides tended to cluster at the beginning of training. Scoville⁸ noted that firearms (in every case, a military-issued M-16 rifle) was the method of choice for soldiers (54%) and marines (50%), while seaman tended to use hanging (67%). Airmen (in all four cases) exclusively used jumping from a height as their method of choice. These inter-service differences may reflect the availability of means rather than a service-related choice.

Although there are no currently published data on the incidence of suicidal ideation or attempts specifically among the recruit population, Rock²³ examined suicidal behaviors in the Army from 1975 to 1984 and found that the annual suicide completions-to-attempts ratio varied from 3:1 to 23:1. Ritchie and colleagues,¹⁵ in their review of the literature on military suicide behaviors, reported suicide attempt rates ranging from 574 to 1,128 per 100,000. In particular, they noted that “the collected data show that in the majority of cases, the large majority of the patients avoided significant lethal means. This is consistent with most of the previous studies that found the majority of patients to be ‘insincere’ in their conviction and ‘superficial’ in their attempt.”^{15(p180)}

Another study²⁴ of suicidal behaviors among teens (age 15–17) in Oregon between 1988 and 1993 reported rates of male and female suicide attempts as 156.1 and 594.4 per 100,000, respectively. At the same time, actual completion rates were 20.2 and 5.6 per 100,000, respectively. Thus, the ratio of nonfatal attempts to completions was 28.2:1 (7.73:1 for boys and 106.1:1 for girls). While girls were 3.8 times more likely to have a nonfatal attempt than boys, boys were 3.6 times as

likely as girls to have a fatal attempt. Although this study involved a younger population than the usual military recruit population, it shows that a disproportionate number of females (per capita) attempt suicide and a disproportionate number of males complete.

In summary, while the percentage of recruits with suicidal ideation is likely to be higher than that of all service members, the actual rates of completed suicide are very low. Although any suicide is one too many, the protective factors inherent in military training environments are a likely cause of the low suicide rate in basic training. Per capita, female recruits are more likely to enact suicidal behaviors (admit to suicidal ideation, self-injure, and make suicidal gestures); male recruits are more likely to complete suicide. In adolescents and in young recruits, suicidal behaviors are more likely to be cries for help than acts intended to result in death.

Problems with Suicide Statistics

Commanders often look at suicide statistics (such as those above) to answer two questions: (1) "Do I have a suicide problem in my unit?" (if the rates increase), or (2) "Did our suicide prevention efforts work?" (if the rates decrease). Unfortunately, suicide statistics are difficult to calculate, difficult to interpret, and rarely, if ever, predictive of future outcomes. Additionally, suicide statistics may not even be accurate or helpful. There are a number of reasons for these problems:

- "The military population is not a random sample of the civilian population and, in fact, differs from it in several systematic ways. The military population is largely male, has a larger proportion of racial minorities, and has virtually no members below the age of 17 and relatively few above the age of 50."^{25(p102)} Too often, individuals with little experience in calculating population statistics are asked to calculate and report suicide rates to commanders or the media. Unfortunately, they often fail to adequately standardize the rates for age, gender, race, or person-years (time and population size) and thereby overestimate or underestimate the actual rates.
- Suicides are rare events, and as such do not conform to normal statistical distributions. Suicidologists usually use Poisson distributions to calculate the probability of rare independent events (suicides) occurring in fixed lengths of time (people-years).²⁶ However, the calculation of these statistics is not always straightforward.²⁷ As mentioned above, too

often well-meaning but inexperienced personnel misapply statistical processes when trying to estimate suicide rates.

- Military reporting systems, particularly before the late 1970s, contain many errors. In the 1970s, Dattel²⁸ examined two different computer systems designed to track military casualties. Although both were supposed to track identical cases, he found only a 63.5% commonality between the two data systems. Dattel also found additional cases not in either computer system. Ultimately, based on his findings, the actual suicide rates could have been reported as 8.4 per 100,000 (from the medical system), 11.0 per 100,000 (from the personnel system), or 16.3 per 100,000 (Dattel's final combined and refined list).²⁹ He sums up his study by stating that the "results are judged to represent an unsatisfactory degree of reliability for scientific purposes. Presumably, they are also unsatisfactory for administrative, planning, or legal use of the information, as well."^{28(p510)}
- There are no international, universally accepted set of definitions or criteria by which to categorize suicidal behaviors.³⁰ Even professionals have difficulty determining intent or classifying suicidal behaviors. Wagner et al.³¹ reported that three groups of professionals (general clinicians using predetermined definitions of suicide, general clinicians not using predetermined definitions of suicide, and suicide researchers) in his study were equally unreliable when asked to classify the intent of 10 possible suicide attempt cases.
- Intent, a major factor in differentiating suicides from accidents,³¹ is difficult to determine, particularly in equivocal cases. Clear intent expressed in a suicide note is left by only about a third of those who complete suicide,³¹ and many suicidal individuals are often ambivalent themselves about what they intend.³⁰ Furthermore, it "is not uncommon for individuals to deny, minimize, or inflate their suicidal intent in the aftermath of the suicidal behavior, either to achieve a desired end (eg, to gain hospital discharge, to cause others to be concerned) or to manage their own anxiety."^{30(p286)}
- Underreporting of suicides can occur because coroners and medical examiners have strict rules on what constitutes a suicide³² or "may be reluctant to impose social stigma, guilt, and loss of insurance benefits on the victim's

family.”³¹ One researcher³³ estimates that the coroner-to-coroner variation of correct suicide determinations may range from 55% to 99%, and Phillips and Ruth³⁴ point out that suicide misclassification may be most pronounced in groups with low official suicide rates (African Americans and women). A recent study by Carr et al³⁵ found that 16% of true military suicides may not be accounted for due to reporting and classification bias.³⁶ Given the very small numbers associated with recruit suicide, a single unreported suicide could have drastic effects on the calculated rates. For example, the US Air Force had four completed basic training suicides in a 25-year period,⁷ so a single suicide would increase or decrease the rate by 25%!

- Finally, most discussions of suicide (as in this chapter) begin with a long presentation of rates and numerical comparisons, which, for the most part, are not helpful. “Studies of suicidal behavior often rely on statistics, incidence rates, and correlations, but these indicators necessarily depend upon the experiences of many individuals.... Statistics,

although important, do not speak of the individual man or woman or tell of his or her pain; they do not offer clues as to when or how to intervene.”^{37(p65)} Worse, suicide statistics may lull professionals into making false assumptions in the course of actual clinical practice. For example, the fact that African American females have lower suicide rates than Caucasian males means little when trying to determine if the female African American sailor sitting across from you is suicidal. Likewise, just because all four Air Force basic trainees committed suicide by jumping⁷ does not mean that suicidal airmen can be trusted with weapons.

In summary, suicide statistics are slippery and difficult to interpret. Even the data upon which they rest are often suspect, and because they are rare events—particularly in recruit populations—single events may send the rates sharply up or down. Most importantly, clinicians must attend to each and every suicidal recruit and listen to each and every story since, as Palmer pointed out, “not everything that counts can be counted, and not everything that can be counted counts.”^{32(p91)}

RISK FACTORS AND VULNERABLE INDIVIDUALS

All populations have multiple stressors, risk factors, and conditions that predispose them to suicide. Some, but not all, of these risk factors may be present in military populations. The military has some unique, military-specific risk factors that must be considered separately, and recruit populations are vulnerable to conditions and experiences that comprise yet another subset of risk factors. See Exhibit 17-1 for a breakdown of population-specific risk factors.

Military-Specific Risk

Active duty military populations experience high levels of stress related to combat, deployment, and family separation. Suicide in the military population often involves legal or occupational difficulties, relationship loss, or public humiliation. In the experience of one of the authors (ECR), based on reviews of numerous cases, the shame of failure precipitates suicide, and direct access to firearms is an added risk.

From 1980 to 1992, 95% of the 3,178 military suicide victims were men and 92% were enlisted. Of the men, 71% were aged 20 to 34, 82% were white, and 61% used a firearm. Information extracted from the US Department of Defense Worldwide Casualty System showed that the suicide risk among military personnel

with routine access to firearms (eg, military security and law enforcement personnel) was significantly higher than the risk for personnel in other military occupations. Collectively, military security and law enforcement specialists had a significant occupational rate ratio (1.25; 95% confidence interval = 1.02–1.53; $P < 0.05$). This corresponds to data on national civilian labor force fatalities, which place police officers and detectives at an elevated risk of suicide. Because the scope and work of these high-risk military groups may differ from service to service, additional occupational information should be examined to facilitate a better understanding of the complex etiology of suicide and to develop appropriate prevention strategies.³⁸

Service members hospitalized for psychiatric reasons are at heightened risk for suicide. After the initial treatment, usually for major depression, they can be returned to duty, placed in a holding company, or moved to a transition unit in the hospital, where they might no longer be under the care of mental health personnel. The stress of facing the loss of their military identity and career in this unstable situation might cause a recurrence of the presenting symptoms, as well as a renewed risk of suicide. Medical personnel should remain alert to the possibility of symptom recurrence in mind. Reemerging symptoms are easy

EXHIBIT 17-1**RISK FACTORS BY POPULATION****General Risk Factors**

- Mood disorder / depression
- Alcohol / drug use or abuse
- Previous suicide attempts
- Family history of depression or suicide
- Thought disorder or cognitive compromise
- Hopelessness or despair
- Single, divorced, or widowed
- Recent losses
- Impulsivity
- Financial hardship
- Physical illness
- Poor social support
- Ethnicity
- Sexual orientation
- Age
- Gender
- Race
- Available lethal means

Risk Factors for Military Populations

- Military occupational specialty involving firearms
- Medical Board processing
- Family stresses from frequent and prolonged deployments
- Psychiatric hospitalization

Risk Factors for Recruit Populations

- Immaturity or adolescent thinking
- Rapid social or environmental change
- High demand / high stress experience
- Homesickness
- Risk increases during certain periods of training
- Narcissistic injury
- Shame or humiliation

Data sources: (1) Helmkamp JC. Occupation and suicide among males in the US Armed Forces. *Ann Epidemiol.* 1996 January;6(1):83-8. (2) Fragala MR, McCaughey BG. Suicide following Medical / Physical Evaluation Boards: a complication unique to military psychiatry. *Mil Med.* 1991 April;156(4):206-9. (3) Wong A, Escobar M, Lesage A, Loyer M, Vanier C, Sakinofsky I. Are UN peacekeepers at risk for suicide? *Suicide Life Threat Behav.* 2001;31(1):103-12. (4) Hall DP. Stress, suicide, and military service during Operation Uphold Democracy. *Mil Med.* 1996 March;161(3):159-62. (5) Brooking JI. Potential psychological problems of Army Medical Services personnel in combat with particular reference to the Territorial Army. *J R Army Med Corps.* 1983;129(3):146-53. (6) Blake JA. Death by hand grenade: altruistic suicide in combat. *Suicide Life Threat Behav.* 1978;8(1):46-59. (7) Kawahara Y, Palinkas LA. Suicides in active-duty enlisted Navy personnel. *Suicide Life Threat Behav.* 1991;21(3):279-90.

to miss in a soldier who has already been treated or is in the process of leaving the military.³⁹

Wong and colleagues⁴⁰ studied suicide among United Nations peacekeepers. They observed that military members who complete suicide experienced psychosocial stresses and psychiatric illness more often than their matched controls. The researchers concluded that although peacekeeping per se does not increase overall suicide risk, the military culture may directly contribute to emotional problems, thereby increasing the number of risk factors. The peacekeepers' military lifestyle may strain interpersonal relationships, encourage alcohol abuse, and contribute to psychiatric illness and suicide in a minority of vulnerable individuals, irrespective of their assignment. Careful selection of peacekeepers, as well as preparatory military training that encourages bonding and mutual support, may mitigate suicide risk.⁴⁰

Recruit-Specific Risk

Today's recruits enter the military with unique generational issues and are more likely to have troubled individual backgrounds than a matched civilian cohort.⁴¹⁻⁴⁴ Although the actual number of completed suicides among recruits is low, suicidal ideation during training is higher than in the general military or civilian populations. Numerous authors have emphasized the stresses of basic training and characteristic vulnerabilities of the young enlisted population.⁴⁵⁻⁵¹

Risk factors found in the military training environment include restricted freedom, the perceived aggressiveness of drill sergeants, the physical and mental demands of training exercises, access to firearms, intolerance for expressing emotional discomfort (often referred to as "whining"), and the stigma (and perceived stigma) of seeking help for emotional or psychiatric problems. Recruits who sought help at one Army mental health clinic frequently discussed how they were ostracized by being called "psycho" or "crazy" by the drill sergeants. Others reported that they were placed together in one squad and forced to respond to roll call as "psychos all present and accounted for." The climate set by leadership has a profound impact on the degree and nature of stigmatization; examples like these occur more often in units whose leaders ignore bullying behavior, or worse, specifically express contempt for vulnerable or symptomatic recruits.^{52,53} The emotional problems recruits bring to military training, along with the pressures of training and the stigma of seeking help for psychiatric issues, all contribute to an increased risk of serious mental health problems, suicidal ideation, and suicidal behavior in the training population.

Research on Risk

Much of the research on specific risk factors for suicide in the general population focuses on the psychiatric diagnoses of depression or mood disorder, personality disorder, and substance abuse.⁵⁴⁻⁵⁸ These risk factors also exist in military populations.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV),⁵⁹ cautions that although suicidal ideation, associated behaviors, and depression are considered significant risk factors for suicide, it is extremely difficult to determine whether a specific depressed patient will attempt suicide, partly because suicide is a very low base-rate behavior.⁶⁰ However, researchers and clinicians have identified risk factors to help predict suicide (see Exhibit 17-2 for a compilation of risk factors by category). Canapary, Bongar, and Cleary state that the presence of one risk factor for suicide may not be enough to increase risk, but as the number of risk factors increases, the risk of eventual suicide increases.⁶⁰

Risk Prediction Models

Sanchez⁶¹ discusses a model for assessing suicide risk that involves determining both risk and protective factors. He discusses the use of historical, personal, psychosocial/environmental, and clinical risk factor categories. Factors that create chronic stress place patients in a higher category of risk than individuals without such stress. The historical factors included in this model are the following: no present significant relationship (single, separated, divorced); frequent unemployment; history of violence; history of childhood abuse; psychiatric diagnosis; history of head injury; history of suicidal behavior; history of mental health treatment; family history of suicidal behavior; recent suicidal behavior (in the last 3 months); and major medical problems. Personal risk factors include unstable emotions, impulsiveness or aggressiveness, inadequate coping skills, poor judgment, personality disorder diagnosis with suicide risk, inadequate problem-solving skills, poor stress tolerance, rigid or distorted thinking, and irrational beliefs. Psychosocial or environmental risk factors include experiencing a major life event (eg, assault), a significant loss, absence of or reduction in social supports, and social isolation. Current clinical factors include specific suicide planning behaviors; changes in mental status; changes in behavior, mood, or attitude; and noncompliance with treatment.

Joiner, Walker, Rudd, and Jobes⁶² described seven different categories of risk factors for suicide: previous

EXHIBIT 17-2

RISK FACTORS BY CATEGORY

Categories of General Risk Factors¹⁻⁸

- Adaptive Capacity/Mental Health Status
 - Low IQ or history of cognitive impairment
 - Personality disorder
 - History of mental illness (possibly undiagnosed)
 - Impairment in problem solving (acute) related to stress, depression, or trauma
- Demographics/Personal Circumstances
 - Unmarried
 - Male
 - White
 - Less education
 - Unemployed
- Social Support
 - Small or poor quality social/interpersonal network
- Physical Health
 - Poor health
- Recent Negative or Traumatic Experience/Loss (risk is usually highest shortly after a loss)
 - Death of family or significant other
 - Rejection by family or significant other
 - Loss of status (job, academic, or training failure)
 - Loss of self esteem (shame, humiliation)
- Recent Emotional State
 - Helplessness
 - Hopelessness
 - Agitated
 - Anxious
 - Depressed
 - Labile mood and/or mood cycling
 - Loneliness or homesickness
- Recent Social Behavior
 - Isolative
 - Hostile
 - Help-rejecting
- Substance Use History
 - Recent use/abuse
 - Frequent use/abuse
 - History of substance tolerance or abuse
- Past History
 - Adverse childhood experiences
 - Abused/neglected in family of origin
 - Past formal psychiatric history
 - Previous suicide ideation/plan/attempts
- Family history
 - Family history of psychiatric disorders
 - Family history of suicide or suicidal ideation
- Genetic loading
 - Suggested by personal and family history of mental health problems and suicide or suicidal ideation

(Exhibit 17-2 continues)

Exhibit 17-2 continued**Acute Risk Factors**⁹⁻¹²

- Recent loss
- Agitation
- Feelings of helplessness/hopelessness
- Substance use/availability
- Evidence of current mood disorder

Warning Signs and Symptoms

A thorough assessment of risk factors remains the best approach to suicide risk prediction. At-risk recruits may communicate or exhibit specific warning signs. Do not ignore these. If present, warning signs increase the likelihood of impending suicide attempt.

- Verbal communication of intent to die and/or seeking help for suicidal ideation^{13,14}
- Suicide notes¹⁵⁻¹⁷
- Odd or violent behavior¹⁸⁻²⁰
- Behavior change or deviance¹³
- Physical symptoms and illness²¹⁻²⁴

IQ: intelligence quotient

Data sources: (1) Sanchez LE, Le LT. Suicide in mood disorders. *Depress Anxiety*. 2001;14(3):177-182. (2) Schneider B, Philipp M, Muller MJ. Psychopathological predictors of suicide in patients with major depression during a 5-year follow-up. *Eur Psychiatry*. 2001;16(5):283-288. (3) Shephard RJ, Brenner IK, Bateman WA, Shek PN. Basic recruit training: health risks and opportunities. *Mil Med*. 2001;166(8):714-720. (4) Simon OR, Swann AC, Powell KE, Potter LB, Kresnow MJ, O'Carroll PW. Characteristics of impulsive suicide attempts and attempters. *Suicide Life Threat Behav*. 2001;32(1 Suppl):49-59. (5) Tuzun B, Polat O, Vatansever S, Elmas I. Questioning the psycho-socio-cultural factors that contribute to the cases of suicide attempts: an investigation. *Forensic Sci Int*. 2000;113(1-3):297-301. (6) Verona E, Patrick CJ, Joiner TE. Psychopathy, antisocial personality, and suicide risk. *J Abnorm Psychol*. 2001;110(3):462-470. (7) Verona E, Sachs-Ericsson N, Joiner TE, Jr. Suicide attempts associated with externalizing psychopathology in an epidemiological sample. *Am J Psychiatry*. 2004 March;161(3):444-451. (8) Williams JO, Bell NS, Amoroso PJ. Drinking and other risk taking behaviors of enlisted male soldiers in the US Army. *Work*. 2002;18(2):141-150. (9) Pfeffer CR. *Suicide in Children and Adolescents*. Child and Adolescent Psychiatry. 3rd ed. Baltimore, Md: LWW; 2003:796-820. (10) Beautrais AL. Risk factors for suicide and attempted suicide among young people. *Aust N Z J Psychiatry*. 2000 June;34(3):420-436. (11) Mann JJ. The neurobiology of suicidal behavior. *Nature Reviews: Neuroscience*. 2003;4:919-928. (12) Allebeck P, Allgulander C. Suicide among young men: psychiatric illness, deviant behaviour and substance abuse. *Acta Psychiatr Scand*. 1990 June;81(6):565-570. (13) Mehlum L. Prodromal signs and precipitating factors in attempted suicide. *Mil Med*. 1992 November;157(11):574-577. (14) Barnes LS, Ikeda RM, Kresnow MJ. Help-seeking behavior prior to nearly lethal suicide attempts. *Suicide Life Threat Behav*. 2001;32(1 Suppl):68-75. (15) Canetto SS, Lester D. Love and achievement motives in women's and men's suicide notes. *J Psychol*. 2002 September;136(5):573-576. (16) He ZX, Yang B, Lester D. Suicide notes of Chinese youth. *Percept Mot Skills*. 2001 August;93(1):317-318. (17) Salib E, El Nimr G, Yacoub M. Their last words: a review of suicide notes in the elderly. *Med Sci Law* 2002 October;42(4):334-338. (18) Escard E, Haas H, Killias M. [Parasuicide and violence: criminological aspects from a study of 21,314 male army recruits in Switzerland]. *Encephale*. 2003 January;29(1):1-10. (19) Koshes RJ, Rothberg JM. Parasuicidal behavior on an active duty army training post. *Mil Med*. 1992 July;157(7):350-353. (20) Lester D. Problem behaviors and suicide and homicide. *Psychol Rep*. 2003 October;93(2):458. (21) Druss B, Pincus H. Suicidal ideation and suicide attempts in general medical illnesses. *Arch Intern Med*. 2000 May 22;160(10):1522-15226. (22) Hoge CW, Lesikar SE, Guevara R, et al. Mental disorders among U.S. military personnel in the 1990s: Association with high levels of health care utilization and early military attrition. *Am J Psychiatry*. 2002 September;159(9):1576-1583. (23) Placidi GP, Oquendo MA, Malone KM, Brodsky B, Ellis SP, Mann JJ. Anxiety in major depression: relationship to suicide attempts. *Am J Psychiatry*. 2000 October;157(10):1614-1618. (24) Struwing JP, Gray GC. An epidemic of respiratory complaints exacerbated by mass psychogenic illness in a military recruit population. *Am J Epidemiol*. 1990;132(6):1120-1129.

suicidal behavior; current suicidal symptoms; precipitant stressors; general symptomatic presentation, including the presence of hopelessness; degree of impulsivity and self control; and other predispositions and protective factors. They posit that a history of a suicide attempt is the most critical factor in risk assessment, thus making individuals who have attempted suicide more than once at an increased risk. Individuals with no history of attempted suicide or only one attempt may or may not be at an increased risk, depending on the other six categories. Based on the presenting symptoms in each category, Joiner and colleagues discuss categories of risk for specific populations, as well as how to handle patients in each category. (A detailed discussion of risk categories and corresponding interventions will follow in the treatment section of this chapter.)

Meichenbaum⁶³ categorizes suicide risk factors into seven domains, including suicidal intent, psychiatric history, psychosocial factors, thought processes, depressive symptoms, self-concept, and unrealistic expectations. As previously mentioned in this chapter, Meichenbaum cautions that there is no single factor or method to predict the likelihood of a suicide attempt. Clinicians need to consider the presence of factors in each of the domains to accurately estimate suicide risk. Meichenbaum's focus in his handbook is devoted primarily to individuals with the diagnosis of post-traumatic stress disorder (PTSD), but he stresses that many patients diagnosed with PTSD also have comorbid depression, which places them at increased risk for suicide.

Another study, conducted in 2001,⁶⁴ reviewed 200 records of adult patients to determine the importance of childhood abuse in assessing suicide risk. Results indicated that patients with a history of childhood abuse (trauma) were more likely to have attempted suicide than patients who had not reported childhood abuse. A history of childhood sexual abuse was more significantly related to current suicidal ideation than childhood physical abuse or a diagnosis of depression. Additionally, individuals with a history of childhood sexual abuse were three times more likely to have a history of sexual assault as adults. Thus, it is important to conduct a thorough risk assessment of individuals with a childhood history of physical or sexual abuse to determine suicidal risk, even in the absence of a mood disorder.^{64,65}

Protective Factors

Clinicians, peers, and the chain of command frequently overlook protective factors and miss critical opportunities to bring about a cognitive shift in the patient. Recognizing protective factors and using these as a basis of therapeutic intervention during the initial assessment can prevent hospitalization, pave the way toward effective outpatient resolution of the suicidal crisis, and boost the chance for successful completion of military training.⁶¹ Protective factors may include marriage, employment, available support system, children, religious affiliation,^{66,67} leisure activities, reason for living,⁶⁸ active involvement in treatment, and effective problem-solving skills.

Although aspects of military training and military culture can constitute potential risk factors, the very structure of military service and the military training environment often serve a protective function. Sheppard points out, "The services are at a distinct advantage in their suicide prevention efforts compared to the population in general. Control of environmental risk factors such as alcohol and drug abuse may play a significant part in the lower suicide rates. The closed community, accessible support services, and readily available early psychological intervention in the military may be factors that help to maintain low suicide rates. Intolerance for sustained misconduct and/or poor performance also serves as a filter for those individuals at high risk for suicide."¹⁶(p170-171)

Suicide Contagion and Epidemics

The prevention of suicide in the military is a subject of intense concern. All military branches have robust suicide prevention plans.⁶⁹ However, the dynamics of suicidal behavior among recruits are not identical to those of other military populations. Recruits threaten suicide to be discharged more frequently than soldiers who are permanently assigned. Concern that an "epidemic" of suicidal ideation may follow successful use of this tactic, and that suicide can be "contagious," is not unfounded. On the other hand, the negative emotional impact of a completed suicide on the training center endures for months to years.

Evidence of the impact one suicidal person's behavior may have on another comes primarily from studies done with adolescents.⁷⁰ Accounts of copycat suicides and suicide clusters are dramatic and frightening.⁷¹⁻⁷³ Nonetheless, some well-designed population-based studies contradict the opinion that exposure to suicide through media accounts or direct exposure to behavior of friends or acquaintances leads to increased rates of suicide. Mercy et al⁷⁰ cite several studies, in addition to their own, that provide evidence of a marginally significant protective effect conferred by association with suicidal behavior of friends or acquaintances.

For military populations, contagion may hinge more on circumstances and intent. The inhumanely harsh circumstances of war and combat accompanied by exhaustion and possible demoralization are more likely to increase the likelihood of "contagious intent." In noncombat military active duty and recruit populations, imitative parasuicide and threatened suicide are more likely to be associated with the desire to leave military service. Parasuicide is defined as all suicidal behaviors—ranging from mild manipulative gestures to intentional suicide attempts—that did not end in death. Tucker reported that 73% of the suicidal patients in his study stated directly at hospital admission, "let me out of the service." Sixty-six percent of this group achieved discharge and 48% did so without psychiatric help. These soldiers were skillful in manipulating their environment, though the majority also had evidence of character problems and failed to function well in multiple settings.⁷⁴

U'Ren reports the same phenomenon in his 1973 paper. Alarmed by the heightened rate of parasuicides among new cadets at West Point in 1970, U'Ren noted, "During July and August [when new cadets are most at risk] not one cadet was seen who seriously wanted to take his own life. Rather, a suicide gesture was a deliberate act made by a cadet who felt that his request to resign from the Academy was being ignored.

Nonetheless, all suicide gestures were taken seriously regardless of conjecture about motivation.”^{75(p645)} Of the 11 men described by U’Ren, 10 resigned from the Academy before the end of their first summer.

U’Ren’s observations instrumentally changed the training policy at West Point. The command decreased the pressure on cadets in 1971. Subsequent analysis found that mental health and suicidal ideation visits dropped significantly while attrition remained constant. In fact, by letting out those who wanted out, the process became not only less painful for all cadets, but also allowed tactical officers and cadet leaders to focus more attention on new cadets who wanted to stay.²

Contagion of suicidal ideation and behavior, like suicidal risk, is multidetermined. Two prominent factors that affect the risk of suicidal contagion for teenagers, soldiers in war, and military recruits are unit (or group) cohesion and morale. Those who are alienated and demoralized are more likely to identify with a suicidal peer.⁵³ In the military, unit cohesion and unit morale are closely related.⁵² Cohesion, which fosters high morale, has two primary components: (1) horizontal cohesion, determined by one’s confidence in and loyalty to peers, and (2) vertical cohesion, determined by one’s confidence in and loyalty to leadership.⁵²

The dynamics of cohesion development in a training unit are different than in a regular unit. In the training unit, the intense focus on group-level rewards and punishments is intended to build esprit de corps—loyalty and commitment to the ideals, values, and structure of the military and respect for and identification with leaders. This becomes the basis for remolding individuals from multicultural civilians into a team that embraces common values, goals, and methods of achieving goals. Successful recruits carry this sense of teamwork on to their first duty assignment. Although horizontal cohesion remains weak in the training unit because of its temporary nature, those who complete the training cycle identify themselves as a special and successful group—an important component of unit cohesion.^{2,75}

During training, high stress, competition, and the need to see oneself as fit and worthy may seriously hinder capacity for empathy with those who struggle—the less fit or less worthy. Although the lack of peer-to-

peer empathy detracts from horizontal cohesion, the constrained training environment and the ubiquitous influence of drill sergeants foster strong vertical cohesion (at least from the trainees toward the cadre). This strong vertical cohesion, along with the example set by the cadre and command, plays the most prominent role in determining a training unit’s overall cohesion and morale, and concurrently influences the risk of suicidal contagion.

Trainees experience especially high levels of stress during the early part of training. During this time trainees are most likely to become symptomatic, and the risk of contagion is highest.^{43,45,76-81} Not every recruit with an acute stress reaction needs a mental health referral, and not every recruit with a mental health referral will fail training. Active implementation of techniques that help recruits manage stress and develop better coping skills, combined with alert observation of those who are unable to benefit from such techniques, will help command more accurately assess who is at high risk. Some suggested techniques to improve stress management include the following:

- Leadership acknowledgment that training is stressful, that overcoming stress has rewards, that those who struggle deserve compassion, and that the military is not for everyone.
- Educational groups for trainees modeled on cognitive-behavioral therapeutic principles that explore the range of responses to the challenges of military training.
- Opportunities for trainees to engage in non-competitive bonding experiences.

Tucker and U’Ren^{74,75} describe varying social and environmental factors that may influence the numbers who might be affected by a parasuicide epidemic:

- Change in likely assignment (ie, recently declared war).
- Change in harshness of training, either because of policy or burned-out training personnel.
- Change in standards for acceptance for training.

RISK ASSESSMENT PROCEDURES

As mentioned in the introduction, risk assessment is a probabilistic calculation of risk, both to the recruit and the military. A recruit who clearly lacks motivation to continue training and appears unable or unwill-

ing to work with mental health personnel to solve problems may be using symptoms to bring about a discharge. A rigorous, well-documented assessment by a licensed mental health professional, a treatment

plan involving at least three to four follow-up visits, continued observation, and other measures appropriate to the symptom presentation will help to clarify the nature and intent of symptoms. In some cases, a clear, nonpunitive discussion of Article 115 of the Uniform Code of Military Justice, Malingering and Self-inflicted Injury to Avoid Military Service, can be helpful. However, this strategy should be carefully weighed; accusing a depressed, symptomatic recruit with poor self-esteem of malingering will cause additional problems and symptoms.⁸²

Recruits are in basic training (boot camp) from 6 to 13 weeks (depending on the branch of service). Although the first 3 weeks are the most difficult for new recruits (and account for many of the new suicidal ideation cases), serious symptoms, including suicide ideation, can occur later in training. Many recruits enter military service with problems that intensify in the training environment. A thorough assessment can sometimes identify problems and diagnoses that will require long-term treatment and/or separation from the service.

The initial management and treatment plan must identify and clearly address the issues relevant to the training environment. Additionally, such a plan needs to be realistic, given the transient nature of the population and the very limited treatment time available. For both those continuing in the military and those being discharged, the plan should also identify problems requiring treatment beyond the training environment and plans to address them.

Echelons of Care

Communication among all levels of personnel in the training environment is critical. This includes the medical community, the chaplaincy, other service agencies, recruit peers, and all levels of command. Decisions about a suicidal recruit start long before the initiation of a mental health assessment. In some cases, a behavioral health provider may never see a recruit who expresses suicidal thoughts, since a referral to behavioral health depends on who is aware of the recruit's plight, how they respond to that knowledge, and what they communicate to others. Individuals in the training environment usually form a hierarchy, serving as "gatekeepers to care" at each level. These levels are generally conceptualized as follows:

- fellow recruits ("buddies," peer class leaders);
- unit command/cadre (drill sergeants, commander, senior enlisted leaders);
- primary medical care personnel (medics, physician assistants, nurses);

- unit ministry team (chaplains and family service center personnel); and
- mental health professionals (military or civilian).

Individuals at each level perform an assessment (formal or informal) and decide how to react. The chapter attachment presents a series of at-risk recruit assessment and management flowcharts for each gatekeeping level. Those closest to the suicidal individual (and therefore most able to discover and/or prevent suicidal behaviors), however, are often the least trained and hence the least likely to see a problem or feel capable of intervening. Even for behavioral health providers trained in suicidology, it is easier to suspect, assess, and react to suicidal ideation in a patient than in a peer or family member. This is commonly referred to as being "too close to the problem." Relational context provides the milieu in which problems are viewed, assessed, and acted upon; thus, gatekeepers at different levels have very different perspectives, motivations, and reactions to a symptomatic recruit. Peers may view fellow recruits as friends and allies, competitors or opponents, capable and competent, or lazy and incompetent. Helping professionals may view recruits as patients with pathology, inductees with acute stress, or as malingerers. How the peer, drill sergeant, or helping professional views the symptomatic recruit will determine the response and assistance rendered. Since those closest to the suicidal recruit are often likely to misperceive suicidal ideation or to be hesitant to act upon their perceptions, suicide prevention training and intervention strategies for these gatekeepers must be presented in their relational and hierarchical context to be effective.

The value of close communication among medical, mental health, religious, and command professionals working with suicidal trainees cannot be overstated. Emotional distress and physical distress are closely related. Initial and/or persistent complaints may be related to medical illness.⁸³ Although medical and behavioral health clinics are typically located in close proximity, problems maintaining contact about patients persist. This communication gap usually grows larger with the inclusion of more organizational structures (eg, between behavioral health and chaplaincy, or between medical staff at the treatment facility and a recruit's command).

Equally important is gathering background information from unit leaders, peer recruits, and family or friends who know the suicidal recruit. Most often, information essential to making a proper assessment can only come from sources who have observed the recruit's behavior in various situations over time.

Failure to gather this information is a grave error. Relying strictly on a self-report makes it difficult to determine if or how the recruit's behavior and mood have changed over time, or whether the recruit has an ulterior motive for reporting suicidal ideation or displaying suicidal behaviors.

In sum, each assessment must answer the critical question, *"Is the recruit sitting with me now about to attempt suicide?"*

Trust and Rapport

Forming a relationship with suicidal and symptomatic recruits, although challenging, is crucial to accurate assessment and effective treatment. In addition to technical training, the requisite skills for forming this relationship include a calm demeanor, clarity, genuine interest, fairness, and empathic understanding. Typically, a recruit in a suicidal crisis feels ostracized, misunderstood, and mistreated by individuals in the chain of command, regardless of the intent of those intervening. Nevertheless, empathic understanding coupled with firmness of action will ensure that the recruit gets care while preparing for successful reintegration once the recruit returns to the unit.

Recruits bring preconceived expectations to the initial behavioral health interview and usually behave in a manner designed to provoke the response they expect: a recruit who expects unfair treatment and who distrusts those in authority may initially associate the interviewer with command and communicate mistrust, anger, and resentment; a recruit expecting to be ignored and neglected may be emotionally withdrawn and hard to reach. Gaining the recruit's trust and confidence in the initial interview is an emotionally and intellectually demanding endeavor. It is extremely important to be aware of and in control of one's own responses to an emotionally distressed recruit.

Many writers have highlighted the significant role of the mental health provider in increasing or decreasing the patient's experience of stigma.⁸⁴⁻⁸⁶ Bachelor and Horvath⁸⁷ point out that the therapeutic relationship established early in the assessment/treatment process is critical to positive mental health treatment outcomes. In particular, they note the importance of therapist attitudes (appropriate empathy, warmth, interest, and genuineness), the balance of exploration with more directive techniques, use of self-disclosure and interpretation, and the therapist's ability to discern a patient's needs accurately.

A productive therapeutic relationship requires the interviewer to communicate what the recruit can expect from him or her at the outset—a thorough discussion of the limits of confidentiality and the parameters

of the therapeutic relationship (ie, access, number of possible evaluation sessions, treatment options).

Finally, it is no less a priority to form relationships with professional colleagues and leaders at all levels of the hierarchy in the training environment. The successful management and treatment of suicidal recruits requires a well-connected community, open communication, and mutual respect among command and support staff at all levels.

Systematic Assessment

Good clinical assessment is an art. Experienced clinicians will often refer to certain patients as having a particular "feel," that is, possessing a set of characteristics that are recognizably diagnostic but too complex to explain. The clinician recognizes and processes these subtle diagnostic characteristics nonverbally and draws conclusions through intuition.⁸⁸ Accurate and reliable clinical intuition develops over time with training and experience. Intuition notwithstanding, a systematic method of assessment remains the foundation of sound clinical judgment (see Exhibit 17-3). John Bowlby cogently stated:

The aim of the practitioner is to take into account as many aspects as he can of each and every clinical problem with which he is called upon to deal. This requires him not only to apply any scientific principle that appears relevant but also to draw on such personal experience of the condition as he may have acquired and, especially, to attend to that unique combination of features met with in each patient. Knowing how greatly patients differ, the experienced clinician recognizes that a form of treatment well suited to one would be totally inappropriate to another. Taking all factors into account and giving each its due weight is the art of clinical judgement.^{89(p40)}

Models of Assessment and Assignment of Risk Category

Those who have done extensive work with suicidal patients have developed excellent procedural models for performing assessments. Rudd, Joiner, and Rajab⁹⁰ describe a comprehensive model for risk assessment with suicidal patients. They recommend a thorough informed consent discussion covering the limits of confidentiality and treatment expectations. This discussion is important with recruits, who are often concerned about who gets what information. Many recruits are under the assumption that everything told to the provider will be completely confidential, when in fact, the clinician may be required to report certain things back to the recruit's command. The

EXHIBIT 17-3**ELEMENTS OF RISK ASSESSMENT**

- Initial contact
- Screening
- Direct interview
 - Therapeutic alliance
 - Informed consent/ confidentiality
 - Precipitating factors/ reasons for suicide
 - Impulse control
 - Depression, despair, hopelessness
 - Seriousness of intent
 - Protective factors and reasons for living
 - Capacity to consider/ verbalize adaptive strategies
 - Nonverbal assessment
 - ◆ Capacity to relate to interviewer
 - ◆ Adaptive capacity
 - ◆ Thought disorder/ cognitive compromise
 - ◆ Emotional tone
 - ◆ Change in quality of relatedness over course of interview
- Collateral information
- Risk determination
- Consultation
- Management plan and expected outcomes
- Documentation
 - Screening instruments
 - Presenting / alerting information
 - Completed risk assessment
 - People contacted and the information provided and received
 - List or account of high-risk and low-risk factors in history
 - Summary of questions, answers, and observations during direct interview
 - Explanation of how all the information led to clinical decisions and actions taken or rejected
 - Management plan, treatment plan, and expected outcomes

model recommends that clinicians be as open and honest as possible with patients, which is especially relevant for recruits, who commonly complain that others, most often the chain of command and drill sergeants, are not being forthright with them. Thus, a thorough informed consent discussion will assist providers in developing rapport and trust with most of the recruit population and in particular, with suicidal patients.

Rudd, Joiner and Rajab⁹⁰ define suicidal risk based on four risk categories: baseline, acute, chronic high-risk, and chronic high-risk with

acute exacerbation. The baseline category is defined as the individual patient's baseline level of functioning (ie, when the patient is functioning at his or her optimum level with essentially no symptoms). The acute category, at the other extreme, occurs when the patient is functioning at his or her worst level, and many symptoms are present. This category is reserved for symptomatic individuals who have never attempted suicide or have attempted it only once. The chronic high-risk category includes individuals who have attempted suicide several times or who have chronic suicidal thoughts, behaviors, or both. The chronic high-risk with acute exacerbation category includes patients who are chronically high risk and are currently presenting with additional symptoms and stressors.

We recommend utilizing a standardized risk assessment instrument similar to the one developed by Rudd, Joiner, and Rajab⁹⁰ for all military clinics serving recruit populations. (A full discussion of assessment instruments is beyond the scope of this chapter; please refer to the references for additional information.⁹¹) Rudd, Joiner, and Rajab⁹⁰ make six recommendations for the initial visit with a suicidal patient:

1. **Establish a routine screening standard policy for suicidal patients.** At one training base, for example, all patients, including those in a suicidal crisis, complete an intake packet including information on the limits of confidentiality and informed consent, a privacy act statement, and standard assessment instruments (for example, the Beck depression inventory⁹² or anxiety inventory⁹³). The clinic assigns one clinician each day to evaluate walk-in patients. Ideally, the designated provider has no other patients scheduled that day. The assessment process and personnel vary among bases. In some cases, a paraprofessional (enlisted technician) sees the recruit first, gathers preliminary information, and immediately staffs the case with a licensed provider. Most military bases have a policy requiring a licensed provider interview for any patient presenting with current or recent suicidal ideation (at a minimum, during the preceding 24 hours). The licensed provider directly interviews the recruit and conducts a full examination, including a formal suicide risk assessment. When the full assessment is completed, the provider assigns the patient a risk category and a severity rating. Use of this guided interview eases the anxiety of both the clinician and the patient, and ensures that all

providers conduct consistent and thorough risk assessments for each patient.

2. **Discuss treatment expectations and informed consent with the patient during the direct interview, and assess each patient for baseline level of functioning using indirect and direct indicators of suicide.** Rudd, Joiner, and Rajab provide a checklist of direct markers, such as frequency, severity, and duration of suicidal thoughts, and indirect markers, such as scores on the Beck depression and anxiety inventories⁹³ and frequency of self-mutilation or other self-destructive behaviors. Additionally, each patient should be instructed to begin self-monitoring suicidal thoughts, including duration, frequency, intensity, and situational triggers of these thoughts.
3. **Focus on building rapport with the patient.** This includes discussing the therapeutic relationship as part of the treatment process, previous psychotherapy and what was and was not effective for the patient, and treatment goals.
4. **Obtain any needed consultation and complete a formal psychological assessment.**
5. **Openly discuss options for treatment,** including inpatient hospitalization, partial hospitalization (a hospital day-program), more frequent outpatient sessions, unit watch, and psychopharmacology.
6. **Develop and document a detailed crisis response plan.** The plan should include information on how the patient can and should respond when feeling suicidal. This should provide many different options for the patient to try, as well as information on accessing emergency services if the suicidal thoughts escalate. This crisis response plan is developed in collaboration with the patient, and one copy is given to the patient and one is placed in the outpatient chart.

Another model of suicide assessment is the Chronological Assessment of Suicide Events (CASE) approach proposed by Shea in 1998, based on 15 years of interview-based research.⁹⁴ Shea designed CASE to be easily learned, remembered, and taught to others; however, the method is limited in scope and covers only vital information about current and recent suicidal ideation and intent. The CASE approach may be useful in a fast-paced setting such as a busy mental health clinic or primary care clinic, but it should be considered a component of a more thorough assessment. It includes four steps:

1. **Inquire about current suicidal thoughts connected to the “presenting event,”**^{94(p61)} including severity of these thoughts. In place of remembering an entire list of questions to ask, clinicians request that the patients tell about their current suicidal attempt or thoughts in a sequential manner. The job of the clinician is to elicit information to complete the patient’s story. By letting patients simply tell their stories from beginning to end (a technique called, “behavioral sequencing”), the clinician can obtain much useful information about the current stressors and any preplanning involved in the most recent suicide attempts or thoughts. In addition to the behavioral sequencing technique, clinicians can use the “gentle assumption” and “denial of the specific”^{94(p64)} techniques with patients hesitant or afraid to discuss suicidal ideation. In gentle assumption, the provider phrases questions in a manner that implies that the behavior has occurred or is occurring. This is to draw the patient into active participation by requiring the individual to discount wrong assumptions. Denial of the specific is used after the patient has denied a specific method of suicide in order to obtain more information through specific questions about other methods. For example, the clinician can ask, “Have you ever thought about hanging yourself?” and so forth, until several other methods of suicide have been discussed with the patient. Use both of these techniques cautiously with recruits, however, because over-reporting is common. Asking this type of leading questions versus open-ended questions could elicit false positive responses.
2. **Obtain information about suicidal thoughts or attempts that have occurred during the past 2 months.** During this process and with the techniques described above, the clinician obtains more information about the extent and duration of planning and preparation for suicide, intent, and level of imminent risk.
3. **Obtain information about past suicidal attempts (that occurred before the last 2 months).** Begin asking about the most serious attempt, followed by the most recent attempt, and then the approximate number of suicide attempts. Reducing this third step to these three questions allows the clinician to obtain essential information while saving time by eliminating the need to discuss each attempt in detail.

4. **Discuss immediate thoughts about suicide that are occurring during the interview and what the patient plans to do after leaving the setting.** This approach is relative to all settings but particularly useful in a fast-paced, busy mental health or primary care clinic.

The Sommers-Flanagan model is limited to describing category and severity of suicide risk. The Sommers-Flanagans⁹⁵ describe suicidal crises along a continuum of five risk categories from nonexistent, through mild, moderate, severe, and finally to extreme. In their model, nonexistent risk is the absence of any risk factors or suicidal ideation. Mild risk involves suicidal ideation with few risk factors and no definite plans. Moderate risk involves suicidal ideation with a plan and the presence of a few risk factors, but the patient has no intent and is able to express reasons for living. Severe risk involves an increase in the intensity and frequency of suicidal ideation combined with a specific and lethal plan, presence of intent, many risk factors, and lack of supports and self-control. Extreme risk includes all of the risk factors and categories from the severe risk level in addition to specific intent to harm oneself.

Methodology: Elements of Suicide Risk Assessment

All licensed mental health professionals should be trained to perform clinical and diagnostic assessments; however, the focus and style of assessment and intervention vary with the training and experience of individual providers. The following list of necessary elements to include in a systematic and thorough assessment of suicide risk was compiled from a review of risk assessment models^{3,5,61,96-100} such as those above (see Exhibit 17-3).

Initial Contact

Phone calls to recruit medical and mental health clinics about distressed trainees are frequent. Clerical staff must have clear guidance for responding to these calls. A scripted triage sheet is a useful tool that provides a tracking record and can include basic demographic information and a few simple questions. In addition to the date and time, name of person calling, and name of trainee, triage information should include presenting concern, presence of suicidal or homicidal ideation, and presence of violent and/or bizarre behavior. Frequently, the commander, drill sergeant, or other initial reporter does not have the information needed to triage a case via telephone (such as the presence or

absence of suicidal ideation). If this is the case, intake staff should ask the reporter to call back with the additional information needed to determine whether the recruit needs immediate assistance. Collecting this additional information, while vital to the ultimate risk assessment and disposition, should not delay other actions needed to secure, transport, or assess the at-risk recruit. It is important to treat all situations of reported or suspected suicidal ideation as emergencies in need of immediate intervention until more information can be obtained.¹⁰¹

Screening

As noted above, standardized screening instruments should be used to ensure that all factors are considered in making risk assessments and to document that assessment (a full discussion of these instruments is beyond the scope of the chapter; please refer to the relevant references^{96,102-104}). Any self-reports should be reviewed before the interview to explore inconsistencies. Distressed individuals often express symptoms in writing that they fail to mention in an interview, and conversely, they may communicate symptoms of distress verbally that they neglect to write about on a form. A quick review of patient forms completed in the waiting room can provide baseline information to speed up the interview; the forms are also a source of potential inconsistencies and paradoxes to be explored verbally with the patient.

The Direct Interview

Therapeutic Alliance. One of the fundamental aspects of any therapeutic endeavor is the formation and use of a positive therapeutic alliance between patient and provider. However, achieving such an alliance with recruits is difficult in the short time available and with the intrusions of other agency responsibilities. Nevertheless, summing up an extensive analysis of 6 decades of empirical outcome studies related to the therapeutic process, Asay and Lambert¹⁰⁵ note that the largest factor in client change appears to be explained by those aspects pertaining to the client and other events beyond the control of the therapist (estimated at 40%). The second largest set of factors—equal to all other therapist-influenced factors combined—involves the working relationship between therapist and patient (estimated at 30% of the change variance). This is an effect twice as great as the variance in therapeutic outcome associated with type of treatment.¹⁰⁵ In other words, the relationship between the recruit and the practitioner is twice as important as the type of treatment.

Based on trust in the relationship, the therapeutic alliance is a dynamic, continuously developing verbal and nonverbal process (see also related literature on “theory of mind”¹⁰⁶⁻¹⁰⁸). The recruit’s initial impressions are rapid, usually unconscious, and based on nonverbal information. This information includes the interviewer’s facial expression, body posture, quality of eye contact, voice quality, emotional tone, and appearance of genuine interest. The patient continuously assesses and reassesses these elements in parallel with the verbal elements of the exchange throughout the interview. The interviewer, likewise, continually assesses the recruit’s nonverbal responses in parallel with his or her verbal presentation. The interviewer is looking for appropriateness or its absence, genuineness, deception, distortions, discontinuities between verbal and nonverbal messages, and meaningful changes. This dialectical process will continue for the duration of the recruit’s relationship to the interviewer.

Informed Consent/Confidentiality. Discuss the limits of confidentiality early in the interview, preferably after introductory and alliance building remarks. Cover these topics even if the recruit is distressed and/or angry. Therapist-client confidentiality does not apply if the clinician determines that the patient is a danger to himself or herself, a danger to others, or gravely disabled (ie, psychotic). Additions to the standard limitations may include a requirement to report information to command or medical specialists on or off post. The need to share information may vary with circumstances and may change through the course of the assessment. Discuss the base policy at the outset, and address additional circumstances as they occur.

Reasons for Considering Suicide. Suicide risk assessment is clearly part of the formal mental health assessment of any distressed recruit. The interviewer should directly explore current and past suicidal thoughts in the interview, expanding the depth of this discussion as the number and significance of risk factors increase.⁹⁵

Ideally the behavioral health professional will have information about suicidal thoughts and intent before the interview. This previously obtained information is extremely important. Although some distressed recruits talk about suicidal thoughts, others remain silent. Evidence of emotional disturbance may be nonverbal or may manifest as disturbed behavior. Although service members who work with recruits may express fear that inquiring directly about suicidal thoughts and impulses will encourage suicidal patients to actually kill themselves, there is no evidence to support this theory.⁹⁸ It is important to correct this misperception, because failure to inquire may delay appropriate mental health assessment and increase the

risk that a distressed recruit will attempt or complete suicide.

Intent. Intent to commit suicide is not the same as suicidal ideation. Passive thoughts of suicide, such as “I wish I was never born” or “I want it all to end” are more common and less intense than intent. One direct way to assess intent is to have patients rate their suicidal intent on a scale from 1 to 10 (1 being no suicidal intent, 10 being extreme intent, or stated another way, “I am planning to kill myself today”).⁹⁵ Direct exploration of intent can be particularly useful with recruits. An illustrative example from one author’s (CD) clinical practice involved a patient who stated he was having current suicidal ideation and had thought of a plan to kill himself. However, when the author asked if the patient intended to kill himself, he responded with a vehement “No!”; he then proceeded to provide several reasons why he would never do anything to harm himself.

Plan. After determining that a recruit is having current suicidal thoughts or plans, explore the specifics. One article suggests that an easy way to remember what to discuss is to use the acronym SLAP,^{95(p44)} for *specificity* of plan, *lethality* of the plan, *availability* of means to go through with the plan, and *proximity* of supports and other protective resources.

Impulse Control. Ask the recruit about perceived level of self-control.⁹⁵ Because self-perception is not always accurate, inquiring about a history of risk-taking behaviors and responses to difficult situations provides additional information about impulse control. Recruits who report slamming fists into walls, using alcohol or other drugs to numb tension or pain, violent responses to provocation, or not remembering doing things witnessed by others are at increased risk for impulsive self-destructive behavior. Suicidal ideation commonly accompanies rage and substance use, and the recruit is more likely to act when angry or intoxicated.

Depression and Degree of Despair. A key component of any suicide risk assessment should be thorough scrutiny of current depressive symptoms and history of depression. Many studies^{59,61-63,95,109} discuss the correlation between suicide and depression, with specific reference to feelings of hopelessness and helplessness. Some studies suggest that hopelessness is more predictive of suicide than other depressive symptoms.^{62,95} The interviewer must investigate suicidal thoughts or behavior that may have occurred during past periods of despair and hopelessness.

Reasons for Living/Protective Factors. Depressed individuals have difficulty spontaneously recalling positive elements of their lives. The recruit may not offer information about goals, family relationships,

children, social support systems, religion, or other meaningful parts of life without direct inquiry. Probing about positive factors also opens a window for therapeutic intervention during assessment and subsequent treatment. The interviewer should observe changes in emotional tone and demeanor during this discussion and be alert for opportunities to foster hope, initiate ways to solve problems, or facilitate meaningful cognitive shifts. Identifying the capacity to take these steps is also of significant prognostic value.

Problem Solving. Depression impairs the capacity for critical thinking and problem solving. The interviewer can assess the degree of impairment and the potential response to therapeutic support by discussing how to use the chain of command and how to enlist support from family or significant others back home. An intervention that is both diagnostic and therapeutic is allowing the patient to call home during the interview. The provider may also request permission to speak to these individuals. Family members may be unaware of the extent of the problems, but they can clarify background information and encourage the recruit to continue help-seeking behaviors. The recruit should be encouraged to use other on-post resources, such as the chaplain or legal services, as time permits within the training environment. During this problem-solving phase of the interview, the clinician should observe changes in the recruit's emotional tone, capacity to relate to the clinician, and capacity to participate in the interview.

Observing Nonverbal Information. The interviewer should gauge the recruit's adaptive capacity throughout the direct interview. In addition to verbal information, much of the assessment will rest on appraisal of the following:

- capacity to engage with the interviewer,
- capacity for problem solving,
- quality of thought (the absence or presence of thought disorder or cognitive compromise),
- change in emotional tone, and
- change in quality of relatedness over the course of the interview.

An improved capacity in any of these areas (corroborated by collateral information) correlates with a decreased suicide risk.¹¹⁰

Collateral Information

The interviewer should collect information about the recruit from the commander, drill sergeant, "battle

buddy," spouse, or parents. Collateral information (along with consultation) is one means of assessing the accuracy of the initial mental health assessment. Initially, ask about past behavior, attitude, quality of relationships, and overall level of function. Information should include records of past mental health treatment (often not reported to military recruiters), inconsistencies between the current level of function and past performance in school or work, peer relationships, and family relationships. This information provides a measure of the recruit's personality and functional capacity in other contexts over time. Information from these contacts may provide specific issues to be addressed in the treatment plan. Most importantly, information gleaned from collateral sources can help determine the extent and seriousness of the recruit's suicidal thoughts and behavior.

Determining Level of Risk

Risk determination is the goal and conclusion of the initial evaluation. After gathering and considering all available information, the clinician must estimate the probability that the recruit will attempt suicide. Assigning the symptomatic recruit to a risk category is a step in the management and treatment process, bearing in mind the immediate goals of maintaining recruit safety and resolving the suicidal crisis (see the section on Management According to Level of Risk).

Consultation

Consultation with another provider can assist clinicians in obtaining feedback about a specific case and offers additional perspectives and techniques for managing suicidal recruits. Because working with distressed and suicidal recruits is inherently stressful, consultation can also assist in decreasing tension and uncertainty. Some opportunities and resources for professional consultation or supervision are

- on-site consultation—consultation with peers or supervision from superiors; and
- military medical centers—contact the behavioral health departments or their individual components (social work, psychology, psychiatry).

Documentation and Communication

Good documentation is imperative.⁹⁵ Medical and behavioral health professionals and technicians need to document each portion of the risk assessment, collat-

eral information obtained from other sources, and any professional consultation obtained. Documentation on consultation is especially critical in the recruit environment, where an unlicensed provider, most often a medic or mental health technician, is frequently the first person to screen a suicidal patient. Finally, documentation must include details about the treatment plan and resources provided to the patient.⁹⁵

Documentation is time consuming. Nonetheless, the chart must reflect sufficient information to communicate the assessment process and management plan to others. It must include the factors that support clinical decisions, the risk/benefit assessment, clinical formulation, and the detailed treatment plan with expected time intervals and expected outcome. Documentation should include the elements listed in Exhibit 17-3.³

MANAGEMENT OF SUICIDAL RECRUITS

The difficulty with assessing and managing suicidal ideation and gestures within a military recruit population stems, in part, from the ambiguity in determining how malingering vs truly suicidal service members should be treated. Everyone would agree that genuinely symptomatic and suicidal recruits should be treated humanely and provided prompt medical attention. Malingerers, on the other hand, require discipline. The distinction is not always clear. Both conditions may be present in some recruits, and an element of malingering does not eliminate the risk of suicide. In any case, concern, fairness, and respectful treatment are the responsibility of all concerned.

As was mentioned in the Echelons of Care section, suicide risk assessment may be initiated by different agents or agencies in the training environment, but the need for communication across agencies and among agents cannot be overemphasized. While the basic elements of the assessment must remain constant, certain aspects may vary according to the focus and training of the agent who begins the assessment (see chapter attachment). The unit command, for example, can ask the recruit screening questions about physical well-being, but primary care or other medical specialists must do the physical evaluation. Also, members of the unit ministry team will need to refer to a physician or other licensed prescriber for medication assessment.

The initial treatment plan must first identify the issues relevant to the training environment that can be addressed during the short initial training period of 6 to 13 weeks. The plan must also identify problems that will require long-term treatment and/or separation from the service for some recruits. After the assessment is completed, the determined risk level, clinical judgment, and available resources will inform the disposition and treatment plan for each symptomatic recruit.

Exhibit 17-4 contains a set of practice guidelines synthesized from the research literature,^{3,5,90,97,110-119} which represent the standard of care in treatment of suicidal patients. Extensive variation in resources and personnel across services and settings requires creative application of these guidelines. Maintaining

the standard of care without omitting crucial elements of assessment and treatment constitutes an ongoing challenge. Several points are critical in the management of suicidal recruits:

- Plan what to do if a suicidal recruit attempts to leave the setting or his or her suicidal ideation escalates. Having a plan in place prior to an incident will ensure a timely and appropriate response.¹⁰³ An effective policy used by two authors of this chapter (CD and RS) prohibited providers from restraining or preventing a recruit from leaving the clinic. When a recruit did leave before being appropriately seen and released, the provider called the military police and the patient's unit to assist with securing the recruit. Most military training units require that a battle buddy or a member of the chain of command accompany suicidal recruits to the clinic. Recruits with suicidal ideation should be escorted at all times, even at the mental health clinic.
- Use the least restrictive treatment setting possible. Experience has shown that the further recruits are removed from their units, the harder it will be to return them to the unit. A symptomatic recruit is more likely to complete training if hospitalization can be avoided.¹²⁰ Anecdotal evidence suggests that more than 75% of psychiatrically hospitalized recruits at one initial entry training (IET) base did not complete training and were later administratively separated from the service.¹²¹ This is congruent with a study by Hoge and colleagues, who found that service members who have been hospitalized for psychiatric diagnoses leave the military at much higher rates than those hospitalized for physical ailments.¹²²
- Establish a good therapeutic alliance. As previously discussed, the therapeutic alliance plays a decisive role in outcome for symptomatic recruits.

EXHIBIT 17-4

GUIDELINES FOR MANAGEMENT AND BRIEF TREATMENT OF SUICIDAL PATIENTS

- Management
 - Assign a risk category.
 - Continue observation, frequent reassessment of suicide risk.
 - Hospitalize if necessary.
 - Adjust outpatient treatment based on level of risk and identified risk factors. The adjusted treatment could include such things as 24-hour access to care, more frequent sessions, group therapy or educational groups.
 - ◆ If the target symptom is suicidal ideation or associated symptoms, treatment may be brief. Incorporate a problem-solving intervention as a key component of treatment.
 - ◆ If the target symptom is to decrease suicidal behaviors and attempts, consider long-term treatment. Focus on skill deficits along with other treatment issues.
- Informed Consent
 - Discuss impact of assessment on military career treatment whenever relevant.
 - Discuss treatment goals based on symptoms, diagnoses, and problems identified and documented in the full assessment.
 - Develop plans to actively track and contact recruits who are noncompliant and/or miss appointments. Develop referral procedures.
 - Discuss the known efficacy, risks, and benefits of the proposed treatment approaches and their expected duration and intended outcome, especially when recommending treatment beyond the current training cycle.
 - Discuss limits of confidentiality regarding suicidal risk, treatment options, risks and benefits of treatment, and estimated duration of treatment.
- Assessment, Monitoring, and Treatment
 - Develop rapport with the suicidal recruit and make the therapeutic relationship an ongoing focus of treatment.
 - Base the treatment on symptoms and issues derived from the assessment and on diagnoses if relevant.
 - Reassess and document recruit status frequently. Monitor for recurrent suicidal ideation and revise treatment plan accordingly. Document revised formulation and revised plan as needed.
 - For recruits at acute intermediate risk, consider short-term therapy with crisis management, development of social support, and problem solving and skill-building interventions.
 - For chronically symptomatic and/or recurrently suicidal recruits at intermediate risk, plan for long-term treatment with interventions focused on changing patterns of relationship, communication, and self-image.
 - Request frequent consultation and/or supervision, document consultation/supervision sessions, and remain alert to your own responses and biases toward the symptomatic recruit.
- Tracking Progress and Treatment Outcome
 - Consistently identify and accurately describe suicide risk factors and risk-related behaviors. These include symptoms such as depression and anxiety, maladaptive personality traits, and other risk-conferring individual characteristics. Suicidal behaviors include suicide attempts, suicidal ideation, suicidal intent and suicidal plans. Document discussions.
 - Identify and discuss identified goals of treatment and progress toward achieving these goals.
 - Regularly assess progress and outcomes using standardized instruments and self-reports.
- Treatment Issues Specific to Young Recruits
 - Involve the family or parents of young suicidal recruits (older recruits may be married). Document this.
 - When the plan calls for sending the recruit home, ensure that the family, parents, or spouse is able to provide the recruit with a safe environment. Document this.
 - Assess the family, parents, or spouse for ability to manage other care-taking responsibilities such as setting limits and providing follow-up care. Document this.

- Ensure that treatment is consistent and based on the patient's level of risk. Rudd, Joiner and Rajab⁹⁰ recommend using a summary sheet to track risk severity levels at each session. A symptom check sheet tailored to the suicidal recruit provides an excellent tool to track the suicide risk, chronology of suicidal ideation, other maladaptive behaviors, clinical improvements, and overall treatment progress.
- If the information needed to make a proper risk assessment is not available, or if the safety or supportiveness of a recruit's unit cannot be assured, consider hospitalization or other protective placement until sufficient information can be gathered to make a sound risk assessment.

Management According to Level of Risk

Low-Risk Category

- Review reasons for concern with the recruit.
- Continue training.
- If there is some risk, assess the recruit periodically for deterioration in status.
- Refer the recruit to a chaplain if supportive counseling is desired.

Recruits who deny active suicidal ideation and who are not experiencing any significant elevation in stressors should be managed by their chain of command. However, chaplains or other providers assigned to IET units should check on low-risk recruits periodically to ensure there is no elevation in their risk status.

Moderate-Risk Category

- Advise the unit command to closely observe and monitor the recruit.
- Consider restriction from risky training activities (eg, live ammunition, jumps from planes).
- Follow up frequently for 24 to 48 hours.
- Initiate therapy in coordination with the unit chaplain or medical personnel.
- Ensure that any physical or medical complaints are evaluated and treated.
- Reevaluate periodically.

Recruits in the moderate-risk category deny any specific plan or intent to kill themselves, yet they have a history of suicidal ideation or behaviors and elevated stressors. These recruits need to be carefully monitored while they are allowed to continue training to the full-

est extent possible. In accordance with combat-stress doctrine, they should remain in their units, be treated by their own chaplains or medical personnel, and be expected to successfully complete training.

Many authors report on strategies to manage patients who are at moderate risk on an outpatient basis.^{62,95,101,123} They recommend frequent sessions that include evaluation and risk level monitoring.¹⁰¹ Two of the authors of this chapter (RS and CD) effectively employed these strategies in one recruit mental health clinic. Providers saw recruits for reevaluation daily for 15 to 20 minutes until the suicidal crisis was defused, and once or twice weekly thereafter for the duration of the training cycle. These recruits concurrently attended a weekly outpatient educational group that focused on development of problem-solving skills, coping, and other stress management techniques.

The considerable current research on treatment for suicidal patients has not supported the efficacy of any specific therapy orientation, setting, or model of treatment.¹¹⁷ Cognitive therapy and dialectic behavior therapy, however, have been shown to be somewhat more effective than standard psychotherapy in treating non-military suicidal adults.¹²⁴

High-Risk Category

- Consider hospitalization or other protective placement.
- Restrict the recruit from risky training activities (eg, live ammunition, jumps from planes) if he or she is retained within the training unit.
- Consider a trial of medication.
- Initiate therapy.
- Ensure that any physical or medical complaints are evaluated and treated.
- Consider medical or administrative discharge.

Following a high-risk determination, the first major decision point is where to place the at-risk recruit to ensure his or her safety. It may be necessary to use inpatient hospitalization to protect the recruit. A military hospital psychiatric unit is better able to manage the military issues of the symptomatic soldier: coordination with command, knowledge of medical requirements for continued service, and knowledge of medical and administrative discharge requirements. At many recruit training bases, however, military inpatient wards are not available, so suicidal recruits have to be placed in off-base civilian psychiatric hospital settings. Sending recruits to a civilian psychiatric hospital brings its own set of challenges and requires considerable liaison with civilian providers.

High-risk recruits who are not hospitalized require constant monitoring and frequent reevaluation until they are stabilized. Managing these recruits on an outpatient basis is often feasible, particularly if the recruit has close friends in the unit and the unit is supportive of the recruit's recovery. The initial treatment plan should include frequent outpatient visits, access to emergency care 24 hours a day, and medication assessment. Treatment focuses on symptom control, problem solving, and building coping skills.^{62,90,101} One study found that high-risk patients can be managed effectively in an intensive outpatient group that incorporates problem-solving skills, as long as inpatient services are available if needed.¹⁸ Options might include a partial hospitalization program with intensive treatment for 6 to 8 hours per day, with the recruit returning to the unit in the evening. However, partial hospitalization in the recruit environment is problematic because transportation to and from the hospital is a drain on the unit, and the recruit will miss critical hours of training (likely resulting in being "recycled" to a new unit to receive the missed training).

Management Plans and Strategies

Unit Watch

The successful use of "unit watch" (also known as "buddy watch," "suicide watch," or "command interest program") to foster retention and positive crisis resolution in the training setting continues to be controversial. The Army originally implemented unit watch "to protect soldiers identified by commanders as minimal suicide risk, and/or 'conditionally suicidal' from potentially harming themselves, or others, while being maintained in the unit."^{125(Para3-43c)} According to regulation, a soldier under unit watch is escorted at all times and is not left unsupervised. The controversy about using unit watch to maintain safety for suicidal recruits and soldiers arises from difficulties with consistent implementation, the intent of the intervention and the variability of outcome.

Positive outcomes from unit watch appear to hinge on social cohesion and morale in the unit, unit support for the recruit in crisis, accurate judgment about the severity of the crisis, and unit awareness of contributing risk factors. Hassinger documents the benefits of unit watch as a management technique for symptomatic soldiers in the 4th Infantry Division.¹²⁶ The soldiers in her sample were young and new to the Army but had completed training. They had a low suicide risk, and 87% were on suicide watch for less than 48 hours. The risk factors were predominately job stress, isolation, and relationship problems. None had severe DSM-IV diagnoses. Hassinger stresses the beneficial role of

mentoring during unit watch to decrease isolation and help young soldiers in crisis integrate more fully into the unit.

Others however, including Hassinger, have reported the negative impact of unit watch resulting from lack of a supportive environment, poor clinical judgment, and failure to appropriately reevaluate the situation at frequent intervals.^{126,127} Perhaps the most in depth discussion of unit watch in IET units was undertaken by the father of a recruit who committed suicide while under unit watch.¹²⁸ While agreeing that unit watch may be a useful and appropriate tool in permanent units with established relationships and good cohesion, the writer states his belief that the technique should not be used in IET units. He lists the following considerations:

- "Unit watch does not remove the patient from the environment that caused the problem. Many young recruits have difficulty adapting to the stress of military life in a basic training camp. Psychological problems occur when the recruit is unable to adapt. Once a trainee psychologically breaks down, he or she is unlikely to recover unless they are removed from the stress that induced the problem. Sometimes the drill sergeant can use counseling to help him or her recover. When that doesn't work, a higher level of care must be given with removal of the soldier from the unit."
- "Unit watch removes the urgency for immediate mental health care. If a [recruit] admits to suicidal thoughts, then [he or she] should be given the same priority as chest pains in relation to heart problems. If a trainee complained of chest pains while doing physical training, would he or she be placed on unit watch and taken to a doctor five days later?"
- Unit watch "places the suicidal [recruit] in an inhumane and humiliating position" and invites abuse toward him or her. "No matter how controlled unit watch in basic training camps is supposed to be...stress from training builds resentment towards anyone deemed [to be] faking mental problems to get out of the military. The design of unit watch makes a spectacle of and is degrading to the soldier being watched. Misguided drill sergeants sometimes encourage this abuse by looking the other way, or worse, by setting an [abusive] example for others to follow."
- Unit watch can be distracting and disruptive to everyone involved since it requires peers and members of the cadre to attend to the at-

risk recruit both day and night.

- Without established mutually supportive relationships (not found in IET units), unit watch does not provide the therapeutic benefits of being among friends as described in combat and operational stress control literature [see US Army Field Manual 8-51, *Combat Stress Control in a Theater of Operations*¹²⁹].
- Unit watch can be (and often is) perverted into a deterrent to suicide contagion and malingering by making a public example of the suicidal recruit through shame and humiliation.
- "Unit watch transfers the responsibility of care from the professional to the untrained."

The military has been historically uneasy about issues of emotional instability and mental health assessment. Military culture responds to the symptomatic recruit warily, depending on unit conditions. A cohesive established unit, such as that described by Hassinger and others, responds to symptoms in one of its own with loyalty, compassion, and attempts to help the symptomatic individual return to his or her previous level of function and reliability.^{52,126} Units lacking cohesion may treat the symptomatic recruit with cool reserve, disdain, or outright contempt. Training units uniformly lack cohesion, especially at the beginning of the training cycle when stress is highest.⁷⁸ Under these circumstances, policies and interventions designed to protect become punitive. The symptomatic recruit in a unit at the beginning of a training cycle is often seen as unfit and unworthy and may be the object of derision. The individual placed on unit watch 24 hours a day certainly has little opportunity to inflict self-harm, but he or she may be isolated, stigmatized, shamed, and humiliated while waiting for the next set of decisions to be made.¹²⁶ The recruit on unit watch is deprived of privacy, shoelaces, and any other conceivable means of self-harm; and, in some units, dressed in fluorescent orange "road guard" vests to ensure they are visible to those monitoring them. He or she quickly becomes a target of ridicule. Such shame, humiliation, and other forms of bullying add both short-term risk and long-term trauma sequelae to the soldier's risk profile.¹³⁰⁻¹³⁷ As pointed out above, complications of unit watch may result in the transferring of responsibility for a suicidal recruit to untrained personnel and/or prevent appropriate assessment altogether.

There is little known about what happens to symptomatic trainees who leave the service. In one follow-up study, well over 50% of the dismissed symptomatic recruits were financially and occupationally unstable.⁷⁴ A related body of literature, on long-term effects of bullying in the workplace, reports that victims of bul-

lying show evidence of physical, psychological, and social or occupational impairment similar to those with PTSD.^{130,131,138,139}

Role of Chaplains

Chaplains are a valuable resource for the recruit population and valuable allies for behavioral health personnel. As well as providing supportive counseling and spiritual guidance, chaplains often provide nurture and hope in what can be an otherwise emotionally harsh environment. Support provided by the chaplaincy, when available and appropriate, may effectively defuse an immediate emergency and provide an ongoing positive alliance to the suicidal recruit and the recruit's cadre. As noted above, good communication between the chaplaincy and the behavioral health providers is critical.

In addition to one-on-one interventions, chaplains, at least in the Army, are responsible for providing suicide prevention training to all recruits. In this role, they periodically brief units on the warning signs of depression and suicidal ideation as well how to access care.

Medical Management

Suicidal recruits frequently present with coexisting conditions that increase diagnostic complexity. Thorough assessment includes the identification and treatment of coexisting physical illness, as well as the use of medication to decrease symptoms associated with depression, insomnia, and other conditions that increase the risk for suicide. Psychotropic medications, used in conjunction with other treatment modalities, have proven effective at reducing symptoms of depression and other conditions.^{90,110,140,141} The evidence for effective use of antidepressants to reduce actual suicide risk is, at this time, less clear. While there is some evidence of benefit from metaanalyses of large population studies,^{142,143} there is also considerable current controversy both inside and outside the military concerning a possible increase in suicidal ideation with antidepressant use.¹⁴⁴ This controversy is compounded by a military culture that looks unfavorably upon the use of psychotropic medication.¹⁴⁵ While a full discussion of this issue is outside the scope of this chapter, effective use of medication requires an appreciation of individual genetic variations, varying cultural beliefs about medication, and the diagnostic complexity of each case. In the short-term, appropriate and skillful use of medication, on a case-by-case basis, may effectively ameliorate specific risk factors. These include high anxiety or panic, depressive symptoms,

problems with cognition, insomnia, and some somatic symptoms. More chronic etiologies may require additional strategies. According to Nemeroff,¹⁴⁶ depression associated with a history of early abuse and neglect responds more effectively to long-term individual therapy, although adjunctive and/or short-term use of medication may successfully improve acute symptoms.

Use of medications within the recruit population generates other complexities. Medication is discouraged (or forbidden) in basic training and recruits rarely have medications in their personal possession. Need for medication in general, and psychotropic medication in particular, carries additional stigma in the military.⁸⁵ This phenomena stems in part from the logical conclusion that service members should not be able to continue in the military if their condition would have made them ineligible to join in the first place. Knowledge that individuals currently taking antidepressants or stimulants for hyperactivity may not be eligible to join the military¹⁴⁷ increases service members' reluctance to take psychotropic medication.

Psychotherapeutic Interventions from the Literature

The literature on treatment of nonmilitary suicidal patients is replete with therapeutic recommendations and techniques. Interventions most frequently encountered include group and individual therapy, marital therapy, pharmacotherapy, and counseling about healthy living habits, such as sleep hygiene techniques and nutrition.

Cognitive behavioral therapy has demonstrated efficacy with individuals and with groups. With suicidal patients, this therapy focuses on fostering more adaptive responses to stress, problem solving, reducing contributing symptoms, and correcting skill deficits and maladaptive personality characteristics. Therapists employ various techniques to explore and alter the patients' suicide belief systems and to help patients recognize and avoid triggering thoughts and mechanisms.^{90,131}

One tool that has been effective with suicidal patients is to have them create, as a homework assignment, an "antisuicide" box that includes items such as mementos, photographs, letters, and other objects that generate positive feelings for them, which can be used as an intervention when they are feeling suicidal in the future. Patients frequently already have something in a pocket or wallet that would meet criteria for their box, and many find this activity enjoyable. Journaling is another technique to assist recruits to explore feelings related to losses in their lives, positive aspects of life, and negative thought patterns.

Meichenbaum⁶³ suggests the use of imagery to assist patients in developing alternative solutions to suicide, by focusing on the positives and negatives of each option, in addition to separating problems into smaller parts. These problem-solving techniques are frequently helpful with recruits, most of whom are young, with underdeveloped coping and problem-solving skills. Assisting them in generating alternative solutions will often decrease the suicidal crisis. If they are able to see alternative solutions to their problems, they often feel more hopeful about their situations. Rudd, Joiner and Rajab⁹⁰ found that problem-solving was a core component of treatment in several studies of suicidal patients.

Rosenberg¹⁴⁸ highlights use of nondirective, affectively based interventions in conjunction with the directive interventions mentioned previously. Some of these include addressing the pain or anger underlying suicidal impulses, praising the patient for seeking help, exploring feelings about death and ambivalence about dying, and emphasizing protective behaviors and positive feelings the patient has about his or her life. She points out that use of both directive and nondirective approaches gives the clinician more flexibility in the treatment of suicidal patients. Linehan¹⁴⁹ has also adapted dialectical behavioral therapy, a technique she developed to use with borderline patients, for use with suicidal patients.

Staff Burnout and Mistakes

The most onerous emotions a human being can experience are terror, desperation, and helplessness. All individuals defend against this emotional pain if they are able. A reduction or loss of these defenses occurs when a person becomes overwhelmed or emotionally disturbed. The emotional distress of others generates a potential variety of feelings in the empathic perceiver, who, in turn, defends against these feelings. The more intense the distress, the more intense is the perceiver's potential response. Without training, and sometimes even with training, those exposed to intensely distressed, provocative, and disorganized patients may act inappropriately in response to their own negative feelings. The most problematic reactions, which may result in errors in recognition, assessment, and management, include the following:

- overt anger,
- denial,
- misperception/distortion,
- dissociation, and
- apathy / failure to respond.

Working with suicidal patients is demanding and stressful for all involved, particularly when caregivers are required to assess and treat large numbers of potentially suicidal recruits. One author of this chapter (CD) reported that the average number of suicidal recruits (in addition to routine appointments) seen in one recruit mental health clinic was five to seven per day. Not only can providers become burned out, everyone

involved with at-risk recruits (eg, command, chaplains, and other recruits) are also at risk of burnout. Thus, there should be a policy for monitoring burnout and a plan for supportive intervention with those who develop symptoms of burnout. Interventions for the cadre ideally contain some or many of the same stress management and problem solving techniques recommended for symptomatic recruits.¹⁵⁰

PREVENTION OF RECRUIT SUICIDE

Although suicides were the second leading cause of death among service members before World War II,¹⁵¹ little action was taken to prevent these tragedies. Perhaps the military's first experience with preventing suicides occurred during World War II in the battle for Saipan, when the Americans used bullhorns and air-dropped leaflets to convince Japanese soldiers and civilians to surrender rather than taking their own lives.¹⁵² Yet in the immediately ensuing years, little was written on institutional suicide prevention programs within the military, although periodic articles on individual clinical assessment and treatment appeared.^{74,76,153-159}

McDowell et al²⁵ suggest three reasons for this phenomena: (1) Suicides were rare events within the military (as noted earlier in this chapter), and they were often masked by the mobility and turnover of the force. (2) Suicide was the purview of the medical department and not considered a command responsibility per se. This arose in part from the tradition of medical battlefield evacuation. Once soldiers were wounded and hospitalized, they were reassigned to medical holding companies until rehabilitated or discharged from the military. Psychiatric casualties were similarly handled, and thus suicidal soldiers became suicidal patients and left both the physical location and attention of unit leadership. And, (3) suicide was "viewed as an individual problem rooted in the pathology of the victim and therefore beyond the control of command authorities."^{25(p102)}

Suicide prevention became a topic of concern among civilian populations in the 1970s and 1980s. At the same time, the military also began to consider the possibility that institutional suicide prevention programs might reduce the number of suicides.¹⁶⁰ In a 1970 editorial, Rosenbaum and Richman¹⁶¹ pointed out that "the military is not the only family of the GI, and it would be an oversimplification to consider it so, but for the time being, the service is his family. We therefore recommend that the Armed Forces look at themselves and their role in the presence and prevention of suicidal behavior."^{161(p500)} They went on to make

three suggestions regarding suicide prevention in the military. First, assess families of symptomatic service members to identify familial issues causing or exacerbating the problems. Second, grant service members more freedom to express dissenting opinions. Finally, establish a 24-hour "suicide prevention service" on each military installation.

Datel,^{28,162-164} and other researchers^{75,165-170} paved the way by calculating the prevalence of suicide in the military services, comparing the various services to civilian populations, and examining subpopulations. Then, in August 1984, the suicide of a 12-year-old boy jump-started the Army suicide prevention program. The boy's family, who lived on an Army base in California while the father served in Korea, often didn't have enough to eat, despite the mother's job. The mother came home from work one day to find that the boy had hanged himself.¹⁷¹

Beside his body was a note on the kitchen table that read: "Dear Mom, I love you, and hope that you won't be angry with me. But I figured that it would help a lot if there was one less mouth to feed."^{172(p1)}

The boy's death prompted Army Chief of Staff General John Adams Wickham, Jr, to order various staff components (personnel, medical, chaplain, etc) to devise a suicide prevention program for the Army.¹⁷¹ According to Colonel Robert Thomas's unpublished history of the Army's suicide prevention program,¹⁷⁰ the psychiatric consultant to the Army Surgeon General balked at the idea of putting together a suicide prevention program because he "did not believe that such a program was needed or that it was even possible to significantly reduce the Army suicide rate. As a result, he did not approach the task with much enthusiasm."^{171(p1)} Frustrated with the Medical Department's response, General Wickham reassigned the project to the Deputy Chief of Staff for Personnel in November 1984, where it landed on then Captain Thomas's desk. Captain Thomas, with the help of Colonel Harry Hallaway

(then chief of psychiatry at the Armed Forces Medical School, now the Uniformed Services University for Health Sciences), successfully created the Army's current suicide prevention program, as codified by the publication of Department of the Army pamphlets 600-70, "Guide to the Prevention of Suicide and Self-Destructive Behaviors" in 1985, and 600-24, "Suicide Prevention and Psychological Autopsy" in 1988.^{173,174}

Although there have been changes in portions of the program (the psychological autopsy most notably¹⁷⁵), many parts of the Army program developed by Captain Thomas remain in use today. Some of these include first-line leader training to recognize warning signs and referral pathways, suicide awareness training of all soldiers by unit chaplains with the assistance of mental health personnel, and data-gathering efforts to track suicides and variables related to each suicide. These items are currently codified in chapter 5 of Army Regulation 600-63, published in 1996.¹⁷⁶

The Army's Training and Doctrine Command has incorporated suicide prevention into recruit training. Regulation 350-6, paragraph 3-43a, reads: "Commanders' and UMTs' [Unit Ministry Team—chaplains and chaplains' assistants] orientations in IET units will include instruction on suicide awareness, and identification of potentially suicidal soldiers. Instruction to soldiers will include the appropriate actions they should take in the event a fellow soldier talks to them about suicide; specifically, soldiers must recognize the need to immediately notify the first cadre member available in the chain of command." In addition, 350-6 requires:

- recruits to be in "buddy teams" of two or more to reduce "the likelihood and opportunity for sexual harassment, misconduct, and suicide gestures or attempts" (para 2-8);
- recruits and the cadre to report any suicidal ideation, gestures, or attempts to the first member in their chain of command (paras 3-31b and 3-43a);
- commanders to immediately refer suicidal recruits in crisis to mental health for assessment (para 3-43b);
- units to provide an escort so the suicidal recruit is never left alone (para 3-46b); and
- chaplains and chaplain's assistants to train the cadre in suicide prevention and intervention (para 3-46d).¹²⁵

As required by regulation 600-63, chaplains provide the all-soldiers training to their assigned units on a

periodic basis,¹⁷⁶ usually every 12 to 24 months. The Army has adopted the ASIST (Applied Suicide Intervention Skills Training) program from Living Works Education, Inc. for leader and "gatekeeper" training. This program is a 2-day course designed to provide front-line leaders, chaplains, chaplain, assistants, and medical personnel a brief overview of suicide and basic intervention skills. The workshops are led by Army chaplains, mental health personnel, and others who have been trained by the Living Works cadre. Most installations offer ASIST workshops once or twice a year.

Before 1995, the US Air Force did not have a formal suicide prevention program.¹⁷⁷ However, high suicide rates in 1994 (16.4 per 100,000) and 1995 (15.8 per 100,000) spurred the Air Force into action.¹⁷⁸ Air Force Surgeon General Charles Roadman II convened a task force that included representatives from 15 functional areas (healthcare, justice, safety, command, operations, social services, health promotion, etc), academia, and the Centers for Disease Control and Prevention to examine the suicide problem and make recommendations for a coherent strategy. The task force developed 11 initiatives (see Exhibit 17-5) that form the backbone of the Air Force's current suicide prevention program. This program led to a significant drop in Air Force suicides during the late 1990s, and was praised by military and civilian experts as a model program.^{177,178} Recently, Air Force suicide rates have been on the increase, perhaps due to personnel turnover, less organizational focus on suicide prevention as a priority, and lapses in suicide prevention training.¹⁷⁷ The Air Force has responded by reinvigorating its suicide prevention program under the direction of its chief of staff.

The Department of the Navy developed suicide prevention programs during the 1980s, but has recently updated its program based on the successes of the Army and Air Force programs. Following the recommendations of subject matter experts from the American Association of Suicidology, Navy Personnel Command, and the Marine Corps, the Secretary of the Navy in August 1998 approved a plan¹⁷⁹ to develop a best-practice approach to suicide prevention. This collaborative effort has resulted in a training package that seeks to reduce modifiable risk factors, strengthen protective factors, and train sailors and marines how to identify and respond to suicide risk among their colleagues. The Navy has adopted the Army's AID LIFE acronym (See Exhibit 17-6) to instruct service members in their duties as first responders.

To combat suicide, the Navy and Marine programs promote early identification of and interven-

EXHIBIT 17-5

US AIR FORCE SUICIDE PREVENTION INITIATIVES

1. **Marketing Community Awareness.** Commanders are encouraged to make appropriate use of mental health services and reminded about command's responsibility as gatekeepers and agents of cultural change to make seeking assistance acceptable.
2. **Leadership Involvement.** The program is endorsed and actively supported by the CSAF. Every 4-6 months the CSAF sends out messages to all Air Force leaders discussing various aspects of suicide prevention.
3. **Investigative Interview Policy.** Required handoff to commander, first sergeant, or supervisor following interviews or interrogations by the OSI, SF, EEO, EOT, or IG.
4. **Professional Military Education.** Included suicide prevention training as part of officer and enlisted Professional Military Education and the First Sergeants course.
5. **Epidemiological Database.** Developed a central surveillance system for tracking fatal and nonfatal self-injuries. Data reported throughout this article was obtained from that source.
6. **Delivery of Community Preventive Services.** Policy permitted mental health professionals to receive credit for engaging in preventive services in non-clinical settings. This was important because medical centers are staffed according to how many patients they treat. Prior to this policy preventive services outside clinical settings were not credited.
7. **Community Education and Training.** Required annual suicide prevention training of all active duty, reserve, guard, and appropriated-funded civilian employees (AFI 44-154).
8. **Critical Incident Stress Management.** Established Critical Incident Stress Teams (AFI 44-153) worldwide to respond to traumatic incidents such as suicide. Teams are multidisciplinary and drawn from mental health, medical, chaplain, Family Support Center, and peers.
9. **Integrated Delivery System (IDS) and Community Action Information Board (CAIB).** The IDS was a revolutionary idea. All the helping agencies on a base were brought together not to report data but to identify the needs of their base and to develop a plan for meeting those needs as a group. In addition, to the individual base IDSs, there were also IDSs for each MAJCOM, and an Air Force level IDS. At each base, MAJCOM, and the Air Force level, a CAIB was created. The CAIB is a cross-functional committee made up of community agencies chaired by the wing or vice wing commander and serves as a policy and decision making forum. When the IDS encounters a community problem they are unable to resolve, they are encouraged to elevate the issue to the CAIB and their MAJCOM IDS.
10. **Limited Patient-Psychotherapist Privilege (AFI-44-109).** Established a policy in which a member being investigated for crimes punishable under the UCMJ and is at increased risk for suicide can be seen by a mental health provider who can establish a mental health record not available to law enforcement agencies. This separate mental health record only applies to that time when the person is at risk for suicide and under investigation. A person can be enrolled in the program at the request of their commander.
11. **Unit Risk Factor Assessment.** The Behavioral Health Survey was created to assess the behavioral health of units. The BHS is under revision and the new version will be released in 03 as the IDS Consultation Assessment Tool (IDS-CAT).

Reproduced from: Air Force Suicide Prevention Program (AFSPP): Overview. Available at: <http://sp.datausa.com/afsppOverview/establishment.html>. Accessed November 18, 2005.

tion for problems, training on warning signs and interventions, effective coping skills development, camaraderie, family and community support, easy access to supportive services, positive work and school environments, and a belief that "it's okay to get help." The approach focuses on understanding patterns of suicide and developing evidence-based interventions to meet the needs of the Navy and Marine Corps communities. In addition, suicide prevention training for leaders is a formal part of the curriculum at all leadership schools. There lead-

ers are taught to know their subordinates and to help with the early detection of problems to prevent suicide.¹⁸⁰

The effectiveness of prevention programs is notoriously hard to document, particularly since suicide is a rare event. The only outcome studies published on the Air Force's suicide prevention program come from the Air Force itself, and their methodology has been called into question.¹⁸¹ Other suicide prevention programs¹⁸¹⁻¹⁸⁴ have been described in the literature, but no outcome measures exist.

EXHIBIT 17-6**THE AID LIFE ACRONYM**

AID LIFE stands for:

A: Ask.	Do not be afraid to ask, "Are you thinking about hurting yourself?" or "Are you thinking about suicide?"
I: Intervene Immediately.	Intervene immediately. Take action. Listen and let the person know he or she is not alone.
D: Don't keep it a secret.	Don't agree to keep anything a secret. You may need help to save your shipmate's life.
L: Locate help.	Seek out the Officer on Duty, chaplain, physician, corpsman, friend, family member, crisis line worker, or emergency room staff.
I: Inform the Chain of Command.	The Chain of Command can secure necessary assistance resources for the long term. Suicide risk does not get better with quick solutions. Effective problem-solving takes time, and the Chain of Command can monitor progress to help avert future difficulties.
F: Find someone.	Find someone to stay with the person now. Don't leave the person alone.
E: Expedite.	Get help now. An at-risk person needs immediate attention from professional care-givers.

Reproduced from: US Naval Academy. Suicide A.I.D. L.I.F.E.

<http://www.nadn.navy.mil/MDC/Clinical/suicide/aidlife.htm>. Accessed November 18, 2005.

In sum, all services have suicide prevention programs. These programs are relatively new (since the mid-1980s) and are still being developed. The Air Force's suicide prevention program is community-based and broadly

targeted, making it a model program. Nevertheless, as the Air Force has found, programs must be correctly implemented and continuously supported or they may flounder.

HELPING SURVIVORS (POSTVENTION)

Historically, interventions following the suicide of a recruit have varied from situation to situation, depending on the training and level of awareness and training of those in command, as well as the availability and training of the installation's behavioral health professional. Although recruit suicide is a rare occurrence, each training center or installation should have a plan for what to do in the event of a suicide. Appropriate management of the post-suicide milieu must include concerted and synchronized efforts by many on-base agencies. This includes the recruit's unit, the military police, the chaplain, medical personnel, and the public affairs department. Failure to adequately prepare for (and perform) "postvention" could lead to further recruit parasuicidal behaviors or unfavorable public scrutiny.

Postvention, defined as a planned intervention for those involved with a person who has recently

committed suicide (family, friends, colleagues, community members, etc) for the purpose of reducing suicidal contagion and facilitating the grief process, is a natural extension of suicide prevention. Crosby and Sacks¹⁸⁵ found that knowing someone who has committed suicide in the previous year may elevate one's own suicidal ideation and behavior. They further point out the importance of postvention as a potential means of reducing this phenomena. Successful postvention elements and interventions have largely been adaptations of interventions used in suicide prevention programs.

Randell et al¹⁸⁶ found that a 2-hour assessment interview followed by a brief counseling protocol and facilitation of school and parental social support significantly reduced risk factors and increased protective factors. Loo¹⁸⁷ described postventions used by the police in Australia that include

- Critical Incident Stress Debriefings (CISDs) conducted by a carefully chosen and trained team;
- documented prearranged postvention procedures;
- one or more follow-up sessions after the CISD to address new concerns and resolve issues;
- proactive notification of families and people concerned with the families (eg, family physician, minister);
- proactive release of official communication stating what is factually known about the suicide soon after the event to minimize rumors (proactive use of public affairs); and
- a postvention evaluation, either written or as a group process, to evaluate the effectiveness of interventions.

A well-designed retrospective study¹⁸⁸ of 83 families in Norway over a 30-year period identified interventions most needed or valued by suicide survivors. The three top interventions were (1) access to professional help (counseling), (2) active professional outreach (ie, the professional contacted the family rather than expecting the family to make the contact), and (3) peer group help.

Based on the findings from the study, the following interventions should be included in a postvention policy or standard operating procedure:

- immediate notification of the chain of command about the facts and circumstances of the suicide;
- immediate notification of next of kin (family) and offering of assistance;
- notification of the public soon after the suicide;

- crisis management briefings for peers, the unit cadre, and the larger community, based on an assessment of the potential impact of the suicide¹⁸⁹;
- continued, active professional outreach to families and peers;
- formal assessment of suicide risk for close friends and family who are not coping well with the loss; and
- a means of evaluating the postvention process to determine its effectiveness and to glean suggestions for improvements.

Emotional reactions that follow death by suicide are not the same as those that follow death from other causes. Family members, friends, fellow recruits, the cadre, clinicians, technicians, and those in leadership positions will each experience some or all of the listed feelings below in the wake of suicide. The cascade of bad feelings is predictable and includes some or all of the following³:

- guilt,
- rage,
- grief,
- surprise,
- need to fix blame,
- sense of betrayal, and
- sense of psychological abandonment.

Suicide is not an easy death. The wounds remain raw. Questions go unanswered. Awareness of the emotional abyss that follows suicide permits the possibility of proactive interventions that may soften the pain. Postvention is intended to contain and transform toxic feelings through hope that healing might eventually begin.

SUMMARY

- The intense military focus on the possibility of suicide is linked to the profoundly disruptive and prolonged impact suicide and parasuicide have on all persons and systems connected with individuals who attempt or successfully complete suicide.
- Suicide is not accurately predictable.
- The actual number of completed suicides among recruits is very low; anxiety about the possibility of suicide is very high. The statistics are imprecise.^{4,29,190} The ratio of suicidal ideation to completed suicide in the general population is approximately 20 to 1. The ratio among recruits, though not specifically known, is much greater because suicidal ideation is more frequent and completed suicides are extremely rare.

- Military training, by its very nature, generates and amplifies risk factors for emotional disturbance and suicide. Military training stresses and challenges recruits beyond previously experienced limits to quickly separate those who are motivated and capable from those who are unmotivated or unable to adapt. Nevertheless, the structure of the military training environment contains inherent protective factors.
- According to one military historian,¹⁹¹ symptoms of the stressed soldier (including suicide intent) are multidetermined and arise from a mixture of suffering and intended manipulation of others.
- Shame, humiliation, isolation and stigma increase the likelihood of suicide attempt and completion.

- Recruits may threaten suicide to get out of military service. These threats may be rooted in desperation, character pathology, or a combination of the two. Separation from the military may be an appropriate intervention. When appropriate, separation from the service should be conducted without humiliation or derision.
- Everyone associated with an at-risk recruit will act (or fail to act) based on their own formal or informal assessment of the risk. Suicide awareness and risk management training, particularly for those who are closely associated with at-risk recruits (recruit peers and the training unit cadre), is essential to reducing risk and improving retention.
- Mental health professionals identify those who are distressed and at risk by completing a thorough and thoughtful suicide risk assessment. They reduce distress and risk by using the results of risk assessment to plan treatment.
- Separating suicidal symptoms from malin-
- gering (also a symptom) is rarely simple or straightforward.
- Unit watch (keeping high-risk recruits in their training units under training restrictions and close observation) is an option that should only be utilized if the recruit's peers and cadre are supportive and not stigmatizing. Although unit watch may keep a recruit safe, if the unit members are not supportive, the recruit's psychosocial well-being will continue to deteriorate.
- All branches of the military have suicide prevention programs and mandate periodic suicide awareness training. The Air Force may have a model suicide prevention program, but constant vigilance and resources are required for any program to remain effective.
- Postvention is a critical component of a good installation-wide suicide prevention program.
- Success in this emotionally demanding work depends on systematic approaches, good methodology, and clear guidelines. Although necessary, none of these is a substitute for human care, compassion, and genuine interest.

REFERENCES

1. Mehlum L. Suicidal ideation and sense of coherence in male conscripts. *Acta Psychiatr Scand.* 1998;98:487–492.
2. U'Ren RC. The nature of change at West Point. *J Am Coll Health Assoc.* 1974;22:185–188.
3. Bongar B. *The Suicidal Patient: Clinical and Legal Standards of Care.* 2nd ed. Washington, DC: American Psychological Association; 2002.
4. Hyams KC, Barrett DH, Duque D, et al. The Recruit assessment program: A program to collect comprehensive baseline health data from US military personnel. *Mil Med.* 2002;167:44–47.
5. Kraemer HC, Stice E, Kazdin A, Offord D, Kupfer D. How do risk factors work together? Mediators, moderators, and independent, overlapping, and proxy risk factors. *Am J Psychiatry.* 2001;158:848–856.
6. Hines AH, Ader DN, Chang AS, Rundell JR. Dual agency, dual relationships, boundary crossings, and associated boundary violations: A survey of military and civilian psychiatrists. *Mil Med.* 1998;163:826–833.
7. Scoville SL. Mortality during US armed forces basic training: A 25-year review (1977–2001) [dissertation]. Bethesda, Md: Uniformed Services University of Health Sciences; 2002.
8. Rothberg JM, Jones FD. Suicide in the US Army: Epidemiological and periodic aspects. *Suicide Life Threat Behav.* 1987;17:119–132.
9. Kerns HN. Cadet problems. *Ment Hyg.* 1923;7:688–693.
10. US Public Health Service. *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC: USPHS; 1999.
11. Canetto SS, Sakinofsky I. The gender paradox in suicide. *Suicide Life Threat Behav.* 1998;28:1–23.

12. Meehan PJ, Lamb JA, Saltzman LE, O'Carroll PW. Attempted suicide among young adults: Progress toward a meaningful estimate of prevalence. *Am J Psychiatry*. 1992;149:41–44.
13. Levi F, La Vecchia C, Lucchini F, et al. Trends in mortality from suicide, 1965–99. *Acta Psychiatr Scand*. 2003;108:341–349.
14. Helmkamp JC. Suicides in the military: 1980–1992. *Mil Med*. 1995;160:45–50.
15. Ritchie EC, Keppler WC, Rothberg JM. Suicidal admissions in the United States military. *Mil Med*. 2003;168:177–181.
16. Sentell JW, Lacroix M, Sentell JV, Finstuen K. Predictive patterns of suicidal behavior: The United States armed services versus the civilian population. *Mil Med*. 1997;162:168–171.
17. Rothberg JM, Ursano RJ, Holloway HC. Suicide in the United States military. *Psychiatric Annals*. 1987;17:545–548.
18. Fear NT, Williamson S. Suicide and open verdict deaths among males in the UK regular armed forces: Comparison with the UK civilian population and the US military. Defense Analytical Services Agency. July 14, 2003. Available at: <http://www.dasa.mod.uk/publications/pdfs/suicide/suicide.pdf>. Accessed April 7, 2004.
19. Feaver D, Kohn RH, eds. *Soldiers and Civilians: The Civil-Military Gap and American National Security*. Cambridge, Mass: MIT Press; 2001.
20. Hooker RD. Soldiers of the state: Reconsidering American Civil-Military Relations. *Parameters*. 2003;33:4–18.
21. Eaton KM, Messer SC, Wilson AL, Hoge CW. Strengthening the validity of population-based suicide rate comparisons: An illustration using US military and civilian data. *Suicide Life Threat Behav*. In press.
22. Partonen T, Schroderus M, Henriksson M, Aro HM, Lonnqvist J. Suicides among draftees: Biphasic occurrence of suicide during military service. *Mil Med*. 1994;159:299–301.
23. Rock NL. Suicide and suicide attempts in the Army: A 10-year review. *Mil Med*. 1988;153:67–69.
24. Centers for Disease Control and Prevention. Fatal and nonfatal suicide attempts among adolescents—Oregon, 1988–1993. *MMWR Morb Mortal Wkly Rep*. 1995;44:312–328.
25. McDowell CP, Rothberg JM, Lande RG. Homicide and suicide in the military. In: Jones FD, ed. *Military psychiatry: Preparing in peace for war*. Washington, DC: Department of the Army, Office of The Surgeon General; 1994:91–113.
26. Kachigan SK. *Statistical Analysis: An interdisciplinary introduction to univariate & multivariate methods*. New York, NY: Radius Press; 1986.
27. Thompson WJ. Poisson distributions. *Comput Sci Eng*. 2001;3:78–82.
28. Datel WE. The reliability of mortality count and suicide count in the United States Army. *Mil Med*. 1979;144:509–512.
29. The reliability of suicide statistics: A bomb-burst. *Suicide Life Threat Behav*. 1980;10:67–69.
30. Wagner BM, Wong SA, Jobes DA. Mental health professionals' determinations of adolescent suicide attempts. *Suicide Life Threat Behav*. 2002;32:284–300.
31. Centers for Disease Control and Prevention. Current trends: Operational criteria for determining suicide. *MMWR Morb Mortal Wkly Rep*. 1988;37:773–774. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001318.htm>. Accessed September 27, 2002.
32. Palmer RN. Suicide—lies...damned lies...and suicide statistics! *Med Sci Law*. 2004;44:90–91.

33. O'Carroll PW. A consideration of the validity and reliability of suicide mortality data. *Suicide Life Threat Behav.* 1989; 19:1–16.
34. Phillips DP, Ruth TE. Adequacy of official suicide statistics for scientific research and public policy. *Suicide Life Threat Behav.* 1993;23:307–319.
35. Carr JR, Hoge CW, Gardner JW, Potter R. Suicide surveillance in the US military—reporting and classification biases in rate calculations. *Suicide Life Threat Behav.* 2004;34:233–241.
36. Carr JR, Hoge CW, Gardner JW, Potter R. Suicide surveillance: Reporting and classification biases in military death records. (unpublished article, 2002).
37. Coben PA, Palinkas LA. A case of suicide. *Mil Med.* 1988;153:65–67.
38. Helmkamp JC. Occupation and suicide among males in the US Armed Forces. *Ann Epidemiol.* 1996;6:83–88.
39. Fragala MR, McCaughey BG. Suicide following Medical/Physical Evaluation Boards: A complication unique to military psychiatry. *Mil Med.* 1991;156:206–209.
40. Wong A, Escobar M, Lesage A, Loyer M, Vanier C, Sakinofsky I. Are UN peacekeepers at risk for suicide? *Suicide Life Threat Behav.* 2001;31:103–112.
41. Rozanov VA, Mokhovikov AN, Stiliha R. Successful model of suicide prevention in the Ukraine military environment. *Crisis.* 2002;23:171–177.
42. Chozinski JP, Bourgeois JA. Psychiatric profiles in the US Air Force: A clinical interpretation of Air Force Instruction 48-123. *Mil Med.* 2001;166:112–115.
43. Cigrang JA, Carbone EG, Todd S, Fiedler E. Mental health attrition from Air Force basic military training. *Mil Med.* 1998;163:834–838.
44. Hourani LL, Warrack G, Coben PA. A demographic analysis of suicide among US Navy personnel. *Suicide Life Threat Behav.* 1999;29:365–375.
45. Armon C, Hadas N, Revach M. Medicine in the basic combat training period (recruits medicine). I: The approach to the recruit. *Mil Med.* 1984;149:579–587.
46. Solis S. Psychosocial stress in Marine Corps officers. *Mil Med.* 1991;156:223–227.
47. Williams RA, Hagerty BM, Yousha SM, Hoyle KS, Oe H. Factors associated with depression in Navy recruits. *J Clin Psychol.* 2002;58:323–337.
48. Datel WE, Lifrak ST. Expectations, affect change, and military performance in the Army recruit. *Psychol Rep.* 1969;24:855–879.
49. Struewing JP, Gray GC. An epidemic of respiratory complaints exacerbated by mass psychogenic illness in a military recruit population. *Am J Epidemiol.* 1990;132:1120–1129.
50. Booth RF, Bucky SF, Berry NH. Predictors of psychiatric illness among Navy hospital corpsmen. *J Clin Psychol.* 1978;34:305–308.
51. Shephard RJ, Brenner IK, Bateman WA, Shek PN. Basic recruit training: Health risks and opportunities. *Mil Med.* 2001;166:714–720.
52. Manning FJ. Morale and cohesion in military psychiatry. In: Jones FD, ed. *Military Psychiatry: Preparing in Peace for War*. Washington, DC: Department of the Army, Office of The Surgeon General; 1994: 1–18.
53. Human Rights Watch. The wrongs of passage: Inhuman and degrading treatment of new recruits in the Russian armed forces. Human Rights Watch 2004;16. Available at: <http://hrw.org/reports/2004/russia1004/>. Accessed October 5, 2005.

54. Chioqueta AP, Stiles TC. Suicide risk in outpatients with specific mood and anxiety disorders. *Crisis*. 2003;24:105–112.
55. Fritsch S, Donaldson D, Spirito A, Plummer B. Personality characteristics of adolescent suicide attempters. *Child Psychiatry Hum Dev*. 2000;30:219–235.
56. Kelly TM, Cornelius JR, Clark DB. Psychiatric disorders and attempted suicide among adolescents with substance use disorders. *Drug Alcohol Depend*. 2004;73:87–97.
57. Rowan AB. Adolescent substance abuse and suicide. *Depress Anxiety*. 2001;14:186–191.
58. Sanchez LE, Le LT. Suicide in mood disorders. *Depress Anxiety*. 2001;14:177–182.
59. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: APA; 1994.
60. Canapary D, Bongar B, Cleary KM. Assessing risk for completed suicide in patients with alcohol dependence: Clinicians' views of critical factors. *Professional Psychology: Research and Practice*. 2002;33:464–469.
61. Sanchez HB. Risk factor model for suicide assessment and intervention. *Professional Psychology: Research and Practice*. 2001;32:351–358.
62. Joiner TE Jr, Walker RL, Rudd MD, Jobes DA. Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional Psychology: Research and Practice*. 1999;30:447–453.
63. Meichenbaum D. *A Clinical Handbook: Practical Therapist Manual for Assessing and Treating Adults with Post-Traumatic Stress Disorder (PTSD)*. Waterloo, Ontario, Canada: Institute Press; 1994.
64. Read J, Agar K, Barker-Collo S, Davies E, Moskowitz A. Assessing suicidality in adults: Integrating childhood trauma as a major risk factor. *Professional Psychology: Research and Practice*. 2001;32:367–372.
65. Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *JAMA*. 2001;286:3089–3096.
66. Nonnemaker JM, McNeely CA, Blum RW. Public and private domains of religiosity and adolescent health risk behaviors: Evidence from the National Longitudinal Study of Adolescent Health. *Soc Sci Med*. 2003;57:2049–2054.
67. Hilton SC, Fellingham GW, Lyon JL. Suicide rates and religious commitment in young adult males in Utah. *Am J Epidemiol*. 2002;155:413–419.
68. Malone KM, Oquendo MA, Haas GL, Ellis SP, Li S, Mann JJ. Protective factors against suicidal acts in major depression: Reasons for living. *Am J Psychiatry*. 2000;157:1084–1088.
69. Shaffer D. *Suicide and Suicide Prevention in the Military Forces: Report of a Consultation*. New York, NY: New York State Psychiatric Institute; 1997.
70. Mercy JA, Kresnow MJ, O'Carroll PW, et al. Is suicide contagious? A study of the relation between exposure to the suicidal behavior of others and nearly lethal suicide attempts. *Am J Epidemiol*. 2001;154:120–127.
71. Phillips DP, Carstensen LL. Clustering of teenage suicides after television news stories about suicide. *N Engl J Med*. 1986;315:685–689.
72. Poijula S, Wahlberg KE, Dyregrov A. Adolescent suicide and suicide contagion in three secondary schools. *Int J Emerg Ment Health*. 2001;3:163–168.
73. Robbins D, Conroy RC. A cluster of adolescent suicide attempts: Is suicide contagious? *J Adolescent Health Care*. 1983;3:253–255.

74. Tucker GJ, Gorman ER. The significance of the suicide gesture in the military. *Am J Psychiatry*. 1967;123:854–861.
75. U'Ren RC, Conrad FE, Patterson PH. A year's experience in student mental health at West Point. *Am J Psychiatry*. 1973;130:643–647.
76. Bourne PG. Some observations on the psychosocial phenomena seen in basic training. *Psychiatry*. 1967;30:187–196.
77. Carbone EG, Cigrang JA, Todd SL, Fiedler ER. Predicting outcome of military basic training for individuals referred for psychological evaluation. *J Pers Assess*. 1999;72:256–265.
78. Clemons EP. Monitoring anxiety levels and coping skills among military recruits. *Mil Med*. 1996;161:18–21.
79. Englert DR, Hunter CL, Sweeney BJ. Mental health evaluations of US Air Force basic military training and technical training students. *Mil Med*. 2003;168:904–910.
80. Koshes RJ, Rothberg JM. Parasuicidal behavior on an active duty army training post. *Mil Med*. 1992;157:350–353.
81. Talcott GW, Haddock CK, Klesges RC, Lando H, Fiedler E. Prevalence and predictors of discharge in United States Air Force Basic Military Training. *Mil Med*. 1999;164:269–274.
82. Schneider B. Techniques for managing Soldiers with equivocal risk for suicide and malingering. Personal communication, August 2005.
83. Druss B, Pincus H. Suicidal ideation and suicide attempts in general medical illnesses. *Arch Intern Med*. 2000;160:1522–1526.
84. Pilgrim D, Rogers AE. Psychiatrists as social engineers: A study of an anti-stigma campaign. *Soc Sci Med*. 2005;61:2546–2556.
85. Porter TL, Johnson WB. Psychiatric stigma in the military. *Mil Med*. 1994;159:602–605.
86. Schlosberg A. Psychiatric stigma and mental health professionals (stigmatizers and destigmatizers). *Med Law*. 1993;12:409–416.
87. Bachelor A, Horvath AO. The therapeutic relationship. In: Hubble MA, Duncan BL, Miller SD, eds. *The Heart and Soul of Change*. Washington, DC: APA Press; 1999. 133–178.
88. Gladwell M. *Blink: The Power of Thinking Without Thinking*. 1st ed. New York, NY: Little, Brown and Company; 2005.
89. Bowlby J. *A Secure Base: Parent-Child Attachment and Healthy Human Development*. New York, NY: Basic Books; 1988.
90. Rudd MD, Joiner T, Rajab MH. *Treating Suicidal Behavior*. New York, NY: Guilford Press; 2001.
91. Range LM, Knott EC. Twenty suicide assessment instruments: Evaluation and recommendations. *Death Stud*. 1997;21:25–58.
92. Beck AT, Steer RA, Brown GK. *BDI-II Manual*. San Antonio, TX: Psychological Corporation; 1996.
93. Beck AT, Steer RA. *Beck Anxiety Inventory Manual*. San Antonio, TX: Psychological Corporation; 1993.
94. Shea SC. The chronological assessment of suicide events: A practical interviewing strategy for the elicitation of suicidal ideation. *J Clin Psychiatry*. 1998;59(suppl 20):58–72.
95. Sommers-Flanagan J, Sommers-Flanagan R. Intake interviewing with suicidal patients: A systematic approach. *Professional Psychology: Research and Practice*. 1995;26:41–47.
96. Cochrane-Brink KA, Lofchy JS, Sakinofsky I. Clinical rating scales in suicide risk assessment. *Gen Hosp Psychiatry*. 2000;22:445–451.

97. Frierson RL, Melikian M, Wadman PC. Principles of suicide risk assessment. How to interview depressed patients and tailor treatment. *Postgrad Med.* 2002;112:65–71.
98. Gutierrez PM, Rodriguez PJ, Garcia P. Suicide risk factors for young adults: Testing a model across ethnicities. *Death Stud.* 2001;25:319–340.
99. Kaplan Z, Benbenishty R, Waysman M, Solomon Z, Bleich A. Clinicians' assessments of suicide risk: Can self-report measures replace the experts? *Isr J Psychiatry Relat Sci.* 1992;293:159–166.
100. Verberne TJ. A developmental model of vulnerability to suicide: Consistency with some recurrent findings. *Psychol Rep.* 2001;89:217–226.
101. Kleespies PM, Deleppo JD, Gallagher PL, Niles BL. Managing suicide emergencies: Recommendations for practitioners. *Professional Psychology: Research and Practice.* 1999;30:454–463.
102. Gaines T Jr, Richmond LH. Assessing suicidal behavior in basic military trainees. *Mil Med.* 1980;145:263–266.
103. Horowitz LM, Wang PS, Koocher GP, et al. Detecting suicide risk in a pediatric emergency department: Development of a brief screening tool. *Pediatrics.* 2001;107:1133–1137.
104. Wright KM, Huffman AH, Adler AB, Castro CA. Psychological screening program overview. *Mil Med.* 2002;167:853–861.
105. Asay TP, Lambert MJ. The empirical case for the common factors in therapy: Quantitative findings. In: Hubble MA, Duncan BL, Miller SD, eds. *The Heart and Soul of Change: What Works in Therapy.* Washington, DC: American Psychological Association; 1999: 22–55.
106. Anderson JR, Bothell D, Byrne MD, Douglass S, Lebiere C, Qin Y. An integrated theory of the mind. *Psychol Rev.* 2004;111:1036–1060.
107. Leslie AM, Friedman O, German TP. Core mechanisms in “theory of mind.” *Trends Cogn Sci.* 2004;8:528–533.
108. Zahourek RP. Intentionality forms the matrix of healing: A theory. *Altern Ther Health Med.* 2004;10:40–49.
109. Brown GK, Beck AT, Steer RA, Grisham JR. Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *J Consult Clin Psych.* 2000;68:371–377.
110. American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors. *Am J Psychiatry.* 2003;160(suppl 11):1–60.
111. Bourgeois JA, Chozinski JP, Walker DM, Orr K, Wisniewski W. Psychiatric treatment and operational readiness: Clinical guidelines for Air Force practice. *Mil Med.* 2001;166:378–381.
112. Cigrang JA, Todd SL, Carbone EG. Stress management training for military trainees returned to duty after a mental health evaluation: effect on graduation rates. *J Occup Health Psychol.* 2000;5:48–55.
113. Crosby RM, Hall MJ. Psychiatric evaluation of self-referred and non-self-referred active duty military members. *Mil Med.* 1992;157:224–229.
114. Hamilton NG. Suicide prevention in primary care. Careful questioning, prompt treatment can save lives. *Postgrad Med.* 2000;108:81–84, 87.
115. Manos GH, Carlton JR, Kolm P, Arguello JC, Alfonso BR, Ho AP. Crisis intervention in a military population: a comparison of inpatient hospitalization and a day treatment program. *Mil Med.* 2002;167:821–825.
116. Newby JH Jr, Van der Heide CJ. A review of 139 suicidal gestures: discussion of some psychological implications and treatment techniques. *Mil Med.* 1968;133:629–637.

117. Rudd MD, Joiner TE Jr, Jobes DA, King CA. The outpatient treatment of suicidality: An integration of science and recognition of its limitations. *Professional Psychology: Research and Practice*. 1999;30:437–446.
118. Staudenmeier JJ, Brown DG. Mental disorders among military personnel. *Am J Psychiatry*. 2003;160:1190–1191.
119. Wilkinson G. Can suicide be prevented? Better treatment of mental illness is more appropriate aim. *BMJ*. 1994;309:860–861.
120. Pullen RL, Labbate LA. Psychiatric hospitalization: Treatment or triage? *Mil Med*. 1992;157:634–636.
121. Hoge CW, Russell RK, Orman DT, Milliken CS, Bliese P. Final report of epidemiologic investigation of outbreak of suicidal behaviors among initial entry Army trainees at Fort Leonard Wood, July–October 2000. Unpublished document, 2001.
122. Hoge CW, Lesikar SE, Guevara R, et al. Mental disorders among US military personnel in the 1990s: Association with high levels of health care utilization and early military attrition. *Am J Psychiatry*. 2002;159:1576–1583.
123. Rudd MD, Rajab MH, Orman DT, Stulman DA, Joiner T, Dixon W. Effectiveness of an outpatient intervention targeting suicidal young adults. *J Consult Clin Psych*. 1996;64:179–190.
124. Brown GK, Ten HT, Henriques GR, Xie SX, Hollander JE, Beck AT. Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA*. 2005;294:563–570.
125. US Army Training and Doctrine Command. *Enlisted Initial Entry Training (IET) Policies and Administration*. Fort Monroe, Va: TRADOC Reg 250–6, para 3–46c.
126. Hassinger AD. Mentoring and monitoring: The use of unit watch in the 4th Infantry Division. *Mil Med*. 2003;168:234–238.
127. Potter M. Private Stites should have been saved. 2004. Available at: <http://www.5280.com/issues/2004/0406/feature.php?pageID=53>. Accessed April 20, 2005.
128. Personal letter from Richard Stites (June 2002).
129. US Department of the Army. *Combat Stress Control in a Theater of Operations*. Washington, DC: DA; 1998. Field Manual 8–51.
130. Bjorkqvist K. Social defeat as a stressor in humans. *Physiol Behav*. 2001;73:435–442.
131. Bond L, Carlin JB, Thomas L, Rubin K, Patton G. Does bullying cause emotional problems? A prospective study of young teenagers. *BMJ*. 2001;323:480–484.
132. Kaltiala-Heino R, Rimpela M, Marttunen M, Rimpela A, Rantanen P. Bullying, depression, and suicidal ideation in Finnish adolescents: School survey. *BMJ*. 1999;319:348–351.
133. Kivimäki M, Virtanen M, Vartiainen M, Elovainio M, Vahtera J, Keltikangas-Järvinen L. Workplace bullying and the risk of cardiovascular disease and depression. *Occup Environ Med*. 2003;60:779–783.
134. Mikkelsen EG, Einarsen S. Relationships between exposure to bullying at work and psychological and psychosomatic health complaints: The role of state negative affectivity and generalized self-efficacy. *Scand J Psychol*. 2002;43:397–405.
135. Nansel TR, Craig W, Overpeck MD, Saluja G, Ruan WJ. Cross-national consistency in the relationship between bullying behaviors and psychosocial adjustment. *Arch Pediatr Adolesc Med*. 2004;158:730–736.
136. Nansel TR, Overpeck MD, Haynie DL, Ruan WJ, Scheidt PC. Relationships between bullying and violence among US youth. *Arch Pediatr Adolesc Med*. 2003;157:348–353.

137. Weir E. The health impact of bullying. *Canadian Medical Association Journal*. 2001;165:1249.
138. Bittner A, Goodwin RD, Wittchen HU, Beesdo K, Hofler M, Lieb R. What characteristics of primary anxiety disorders predict subsequent major depressive disorder? *J Clin Psychiatry*. 2004;65:618–626.
139. Fekkes M, Pijpers FI, Verloove-Vanhorick SP. Bullying behavior and associations with psychosomatic complaints and depression in victims. *J Pediatr*. 2004;144:17–22.
140. Emslie GJ, Mayes TL, Laptook RS, Batt M. Predictors of response to treatment in children and adolescents with mood disorders. *Psychiatr Clin North Am*. 2003;26:435–456.
141. Friedman MJ, Charney DS, Southwick SM. Pharmacotherapy for recently evacuated military casualties. *Mil Med*. 1993;158:493–497.
142. Hall WD, Mant A, Mitchell PB, Rendle VA, Hickie IB, McManus P. Association between antidepressant prescribing and suicide in Australia, 1991–2000: Trend analysis. *BMJ*. 2003;326:1008.
143. Isacson G, Rich CL. Antidepressant drug use and suicide prevention. *International Review of Psychiatry*. 2005;17:153–162.
144. Healy D, Whitaker C. Antidepressants and suicide: Risk-benefit conundrums. *J Psychiatry Neurosci*. 2003;28:331–337.
145. Beighley PS, Brown GR. Medication refusal by psychiatric inpatients in the military. *Mil Med*. 1992;157:47–49.
146. Nemeroff CB, Heim CM, Thase ME, et al. Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proc Natl Acad Sci U S A*. 2003;100:14293–14296.
147. US Department of the Army. *Standards of Medical Fitness*. Washington, DC: DA; 2005. Army Regulation 40-501.
148. Rosenberg JM, Fagan J, Shaw J. Suicide prevention: An integrated training model using affective and action-based interventions. *Professional Psychology: Research and Practice* 1999;30:83–87.
149. Linehan MM. *Cognitive-behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press; 1993.
150. Britt TW, Adler AB. Stress and health during medical humanitarian assistance missions. *Mil Med*. 1999;164:275–279.
151. Rothberg JM, Fagan J, Shaw J. Suicide in United States Army personnel, 1985–1986. *Mil Med*. 1990;155:452–456.
152. Suzuki PT. Suicide prevention in the Pacific War (WW II). *Suicide Life Threat Behav*. 1991;21:291–298.
153. Pozner H. Suicidal incidents in military personnel. *Br J Med Psychol*. 1953;26:93–109.
154. Fisch M. The suicidal gesture; a study of 114 military patients hospitalized because of abortive suicide attempts. *Am J Psychiatry*. 1954;111:33–36.
155. Offenkrantz W, Church E, Elliott R. Psychiatric management of suicide problems in military service. *Am J Psychiatry*. 1957;114:33–41.
156. Otto U. Suicidal attempts made during compulsory military service. *Acta Psychiatr Scand*. 1963;39:298–308.
157. Kiev A, Giffen MB. Some observations on airmen who break down during basic training. *Am J Psychiatry*. 1965;122:184–188.
158. Hauschild TB. Suicidal population of a military psychiatric center. A review of ten years. *Mil Med*. 1968;133:425–436.
159. Sawyer JB. An incidence study of military personnel engaging in suicidal behavior. *Mil Med*. 1969;134:1440–1444.

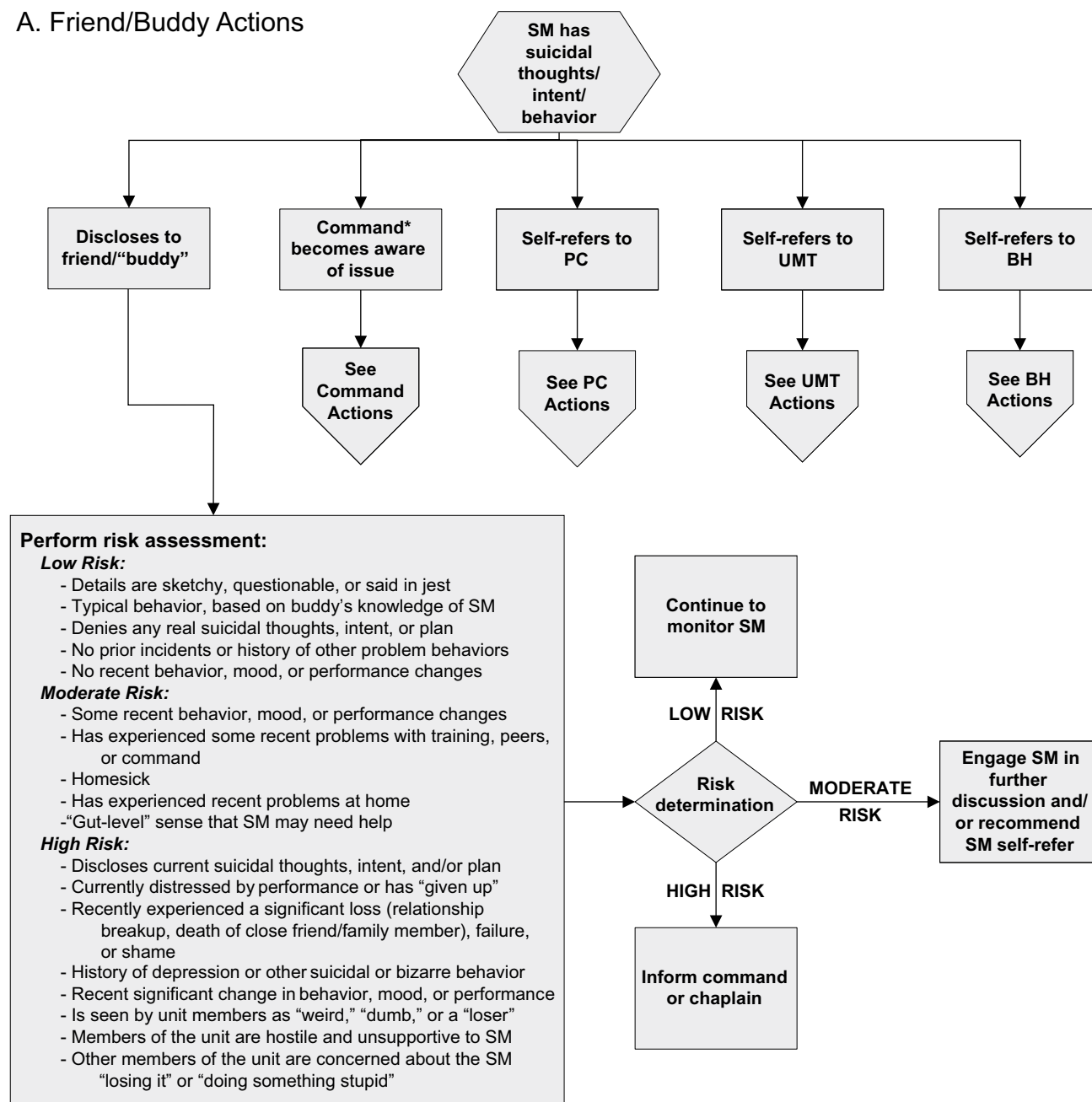
160. Thomas RW, Rothberg JM. Suicide prevention in the US Army: A program comes of age. Proceedings of the 23rd Annual Meeting of the American Association of Suicidology; 1990; New Orleans, La.
161. Rosenbaum M, Richman J. Suicide prevention in the military. *Mil Med.* 1970;135:500–501.
162. Datel WE, Johnson AW Jr. Suicide in United States Army personnel, 1975–1976. *Mil Med.* 1979;144:239–244.
163. Datel WE, Jones FD, Esposito ME. Suicide in United States Army personnel, 1977–1978. *Mil Med.* 1981;146:387–392.
164. Datel WE, Jones FD. Suicide in United States Army Personnel, 1979–1980. *Mil Med.* 1982;147:843–847.
165. Flinn DE, Leonard CV. Prevalence of suicidal Ideation and behavior among basic trainees and college students. *Mil Med.* 1972;137:317–320.
166. Spaulding RC, Edwards DE. Suicide attempts: An examination of occurrence, psychiatric intervention, and outcome. *Mil Med.* 1975;140:263–267.
167. Hoiberg A, Garfein AD. Predicting suicide gestures in a naval recruit population. *Mil Med.* 1976;141:327–331.
168. Wasileski M, Kelly DA. Characteristics of suicide attempters in a Marine recruit population. *Mil Med.* 1982;147:818–830.
169. Manning FJ, Ingraham LH. Drug “overdoses” among US soldiers in Europe, 1978–1979. I. Demographics and toxicology. *Int J Addict.* 1983;18:89–98.
170. Manning FJ, Ingraham LH, DeRouin EM, Vaughn MS, Kukura FC, St Michel GR. Drug “overdoses” among US soldiers in Europe, 1978–1979. II. Autopsies following deaths and near-deaths. *Int J Addict.* 1983;18:153–166.
171. Thomas RW. History of the Army suicide prevention program (unpublished article, 2000).
172. Brown JL. Poverty in America: How did the working get so poor? Available at: <http://www.centeronhunger.org/pdf/JCPA.pdf>. Accessed April 22, 2005.
173. US Department of the Army. *United States Army Guide to the Prevention of Suicide and Self-Destructive Behavior*. Washington, DC: DA; 1985. DA PAM 600–70.
174. US Department of the Army. *Suicide Prevention & Psychological Autopsy*. Washington, DC: DA; 1988. DA PAM 600–24.
175. Ritchie EC, Gelles MG. Psychological autopsies: The current Department of Defense effort to standardize training and quality assurance. *J Forensic Sci.* 2002;47:1370–1372.
176. US Department of the Army. *Army Health Promotion*. Washington, DC: DA; 2005. Army Regulation 600–63.
177. Callander BD. Suicide in the ranks. *Air Force Magazine.* 2005;88:52–54.
178. Knox KL, Litts DA, Talcott GW, Feig JC, Caine ED. Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *BMJ.* 2003;327:1376.
179. US Department of the Navy. *US Navy Suicide Prevention Program: 1998*. Washington, DC: 1998.
180. US Department of the Navy. Suicide Prevention. *Marine Corps News Weekly*. Washington, DC: 2000.
181. Centers for Disease Control and Prevention. Suicide prevention among active duty Air Force personnel—United States, 1990–1999. *MMWR Morb Mortal Wkly Rep.* 1999;48:1053–1057.
182. James LC, Kowalski TJ. Suicide prevention in an Army infantry division: A multi-disciplinary program. *Mil Med.* 1996;161:97–101.

183. Stea JB, Anderson MA, Bishop JM, Griffith LJ. Behavioral health force protection: optimizing injury prevention by identifying shared risk factors for suicide, unintentional injury, and violence. *Mil Med.* 2002;167:944–949.
184. Porter LS, Astacio M, Sobong LC. Telephone hotline assessment and counselling of suicidal military service veterans in the USA. *J Adv Nurs.* 1997;26:716–722.
185. Crosby AE, Sacks JJ. Exposure to suicide: Incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide Life Threat Behav.* 2002;32(3):321–328.
186. Randell BP, Eggert LL, Pike KC. Immediate post-intervention effects of two brief youth suicide prevention interventions. *Suicide Life Threat Behav.* 2001;31(1):41–61.
187. Loo R. Effective postvention for police suicide. *Australasian Journal of Disaster and Trauma Studies* 2001;2001–2002. Available at: <http://www.massey.ac.nz/%7Etrauma/issues/2001-2/loo.htm>. Accessed April 7, 2004.
188. Dyregrov K. Assistance from local authorities versus survivors' needs for support after suicide. *Death Stud.* 2002 ;26(8):647–668.
189. Mitchell JT, Everly GJr. *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services*. 3rd ed. Ellicott City, Md: Chevron Publishing Corp; 2001.
190. Wagner SA, Clark MA. US Navy and Marine Corps recruit training deaths in San Diego, California, 1973–1985; a review of 31 cases. *J Forensic Sci.* 1992;37:185–194.
191. Shephard B. *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century*. Cambridge, Mass: Harvard University Press; 2001.

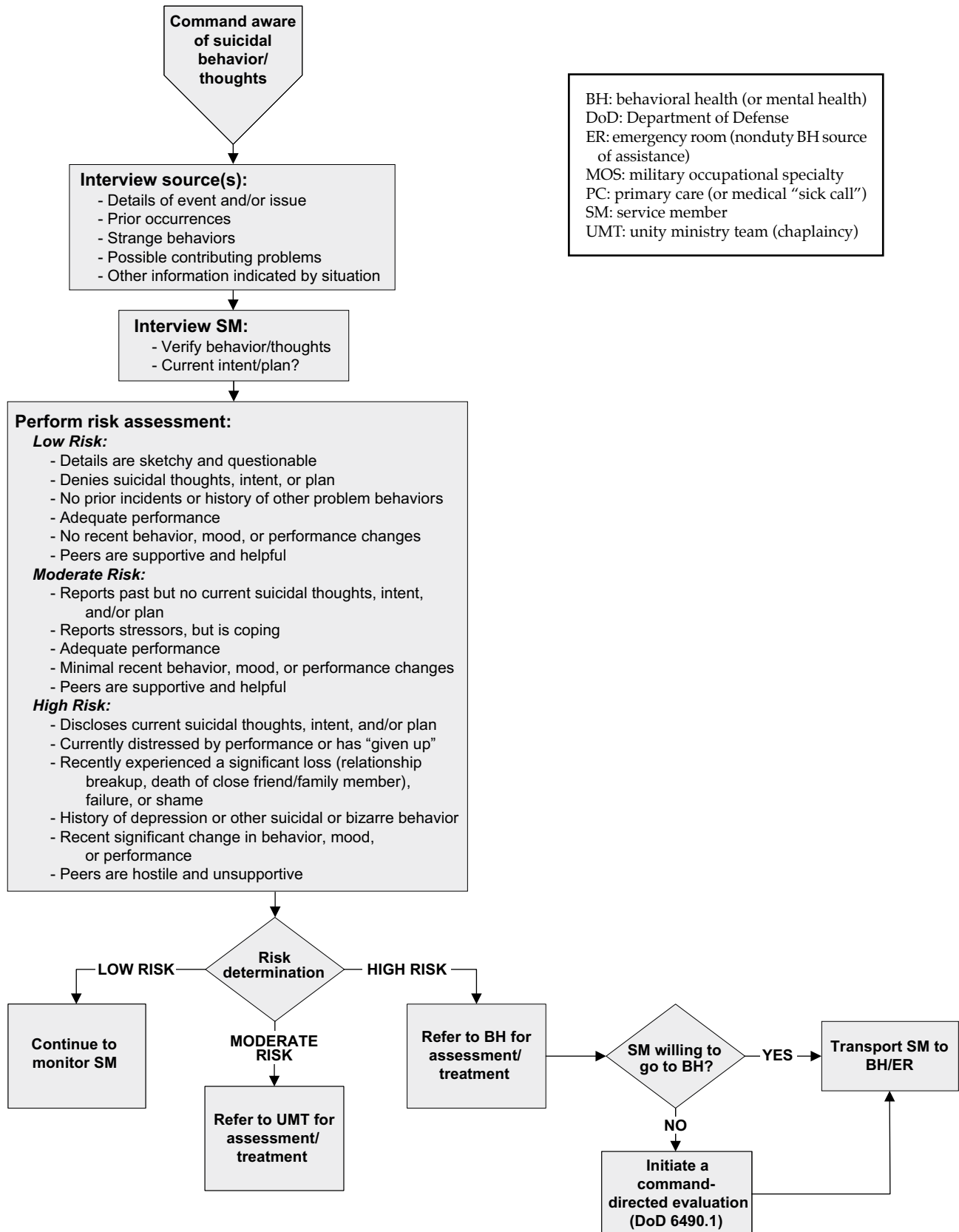
CHAPTER 17 ATTACHMENT: RISK-MANAGEMENT FLOWCHARTS

Flowcharts for assessing and managing at-risk recruits at each gatekeeping level: (a) friend or “buddy”; (b) command (the SM’s drill sergeant, commander, or other’s within the SM’s chain of command); (c) primary caregiver; (d) unity ministry team; and (e) behavioral or mental health practitioners. These flowcharts present a general use in “cookbook” fashion). The flowcharts make four assumptions: (1) the “behavioral healthcare system” includes everyone involved with at-risk recruits, from their closest buddy to their command and beyond; (2) those closest to the at-risk recruit (buddies and drill sergeants) are most likely the first to observe problems, know the recruit the best (within the training environment), and will be the most powerful interveners (for good or ill); (3) personnel at all levels will take (or not take) certain actions based on a formal or informal risk assessment informed by the available facts (or lack thereof); (4) recognizing, training, and empowering these early decision makers will directly reduce the suicide risk and improve the overall outcome of at-risk recruits.

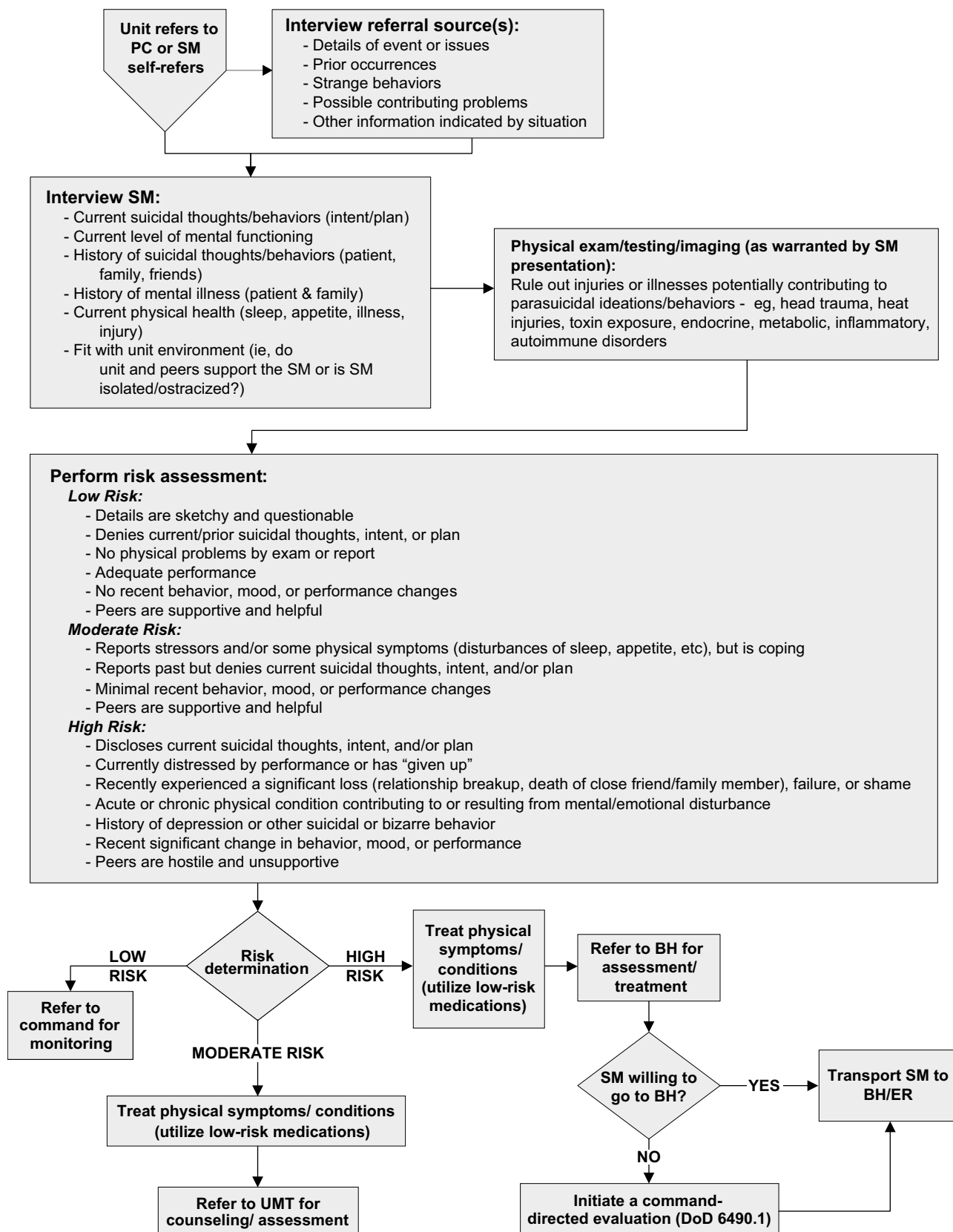
A. Friend/Buddy Actions



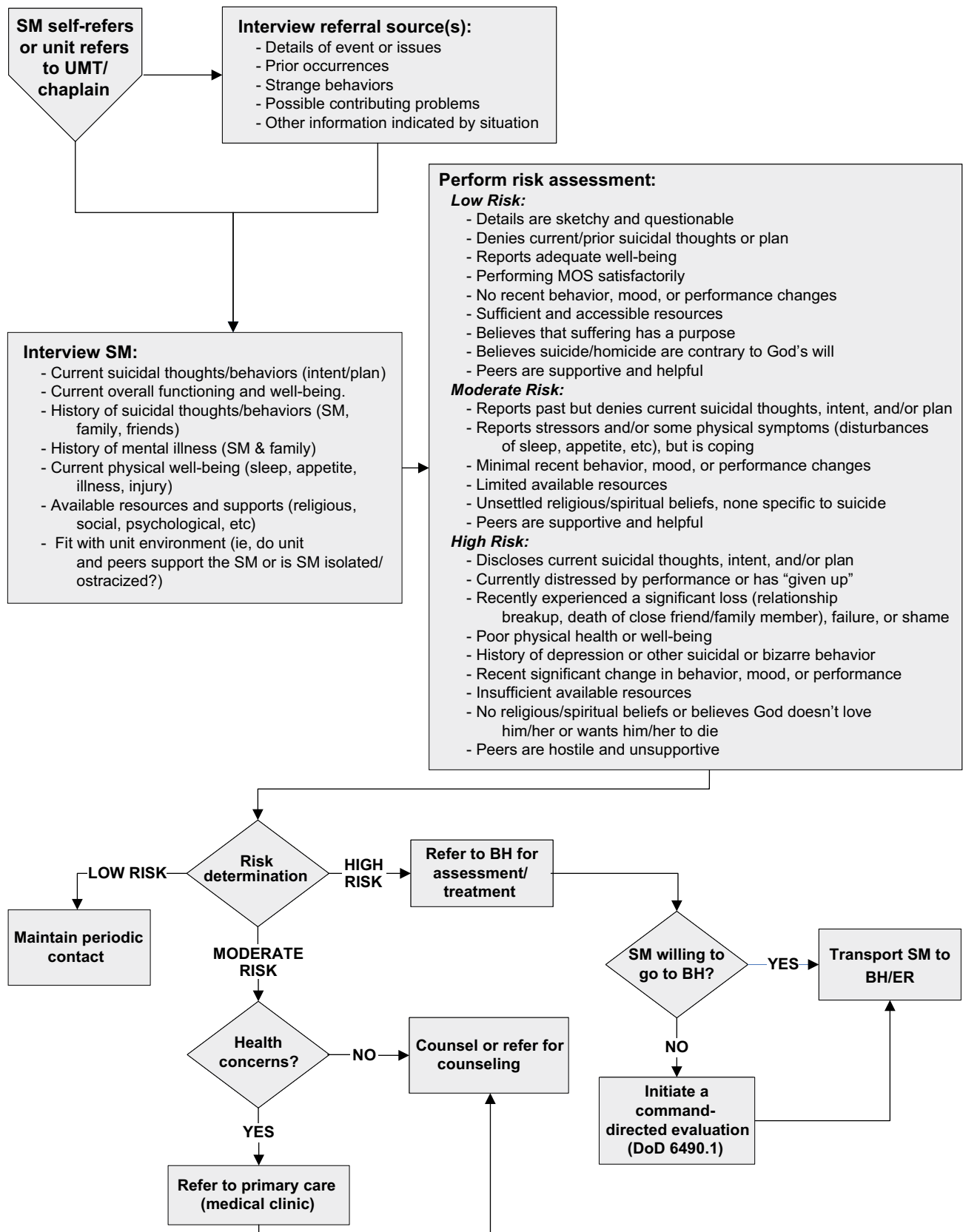
B. Command Actions



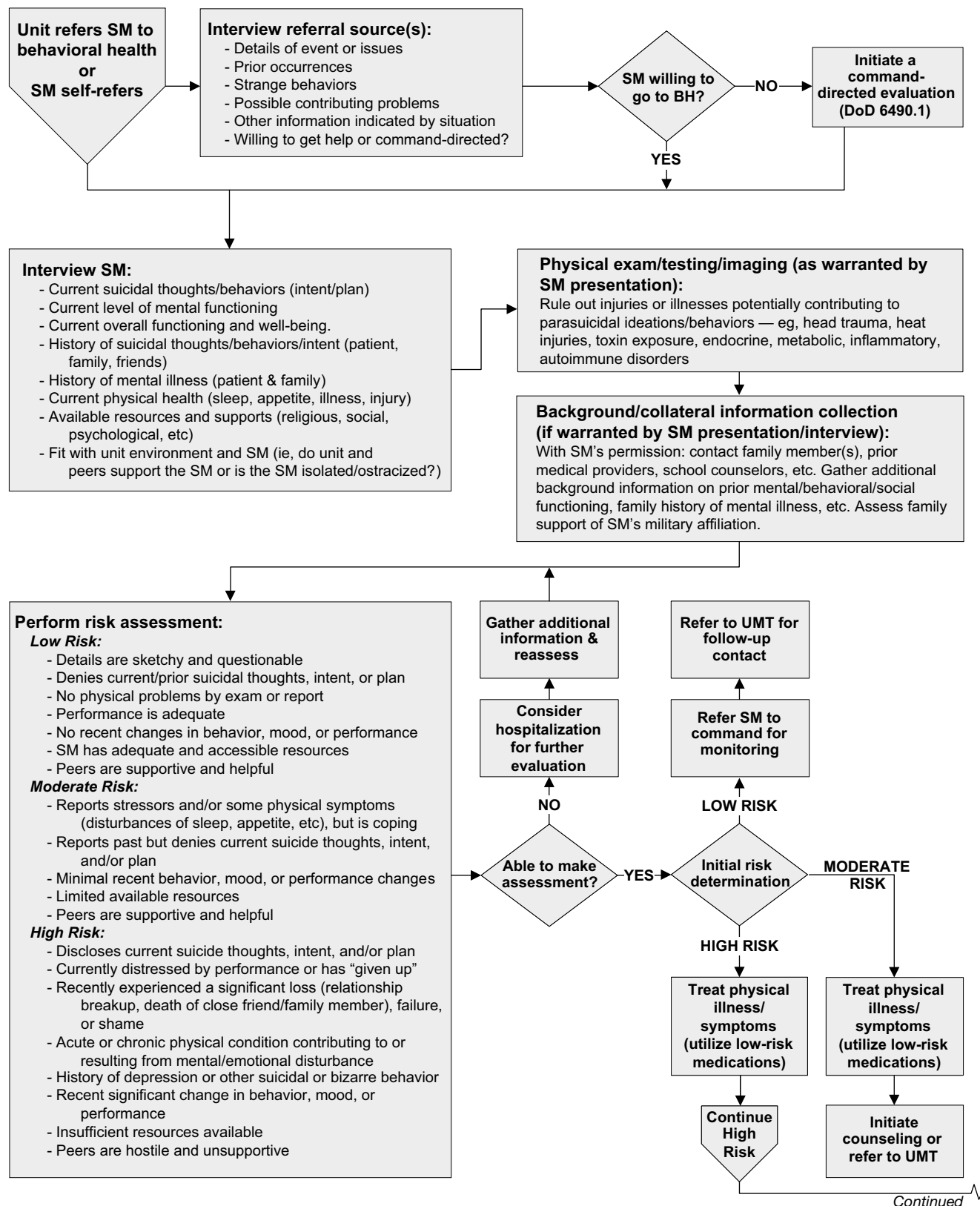
C. Primary Care Actions



D. Unit Ministry Team Actions



E. Behavioral/Mental Health Provider Actions



High Risk, Continued

Assessment of suicidal behavior:

Acute/Situational:

- Reports current suicide thoughts, intent, and/or plan
- Denies prior history of suicidal thoughts/behaviors
- No history of depression, mental illness, or bizarre behavior
- Currently distressed by performance failure /acute hopelessness
- Recently experienced a significant loss (relationship breakup, death of close friend/family member), failure, or shame
- Acute physical condition contributing to or resulting from mental/emotional disturbance
- Recent behavior, mood, or performance changes
- Homesickness
- Problems with command/peer relationships

Chronic:

- Reports current suicide thoughts, intent, and/or plan
- Prior history of suicidal thoughts/behaviors
- History of depression, mental illness, or bizarre behavior
- Current or past history of thought and/or mood disorder and/or cognitive impairment
- Describes long-standing bouts of hopelessness
- History of multiple significant losses (relationship breakup, death of close friend/family member), shame and/or failures
- Acute/chronic physical condition contributing to or resulting from mental/emotional disturbance
- Recent behavior, mood, or performance changes
- Problems with command/peer relationships

Manipulative:

- Discloses current suicide thoughts, intent, and/or plan
- Currently discouraged by performance or has "given up"
- Sees getting out of military as best coping mechanism
- Vague or no history of depression, suicidal or bizarre behavior
- Significant problems with command/peer relationships

Assessment of protective factors (resources):

Biological Resources:

- No familial history of depression or other mental illness

Psychological Resources:

- Strong problem-solving skills
- Good impulse control
- Wants to succeed/complete training
- Does not want to die (no intent to die)

Social Resources:

- Forms and maintains therapeutic alliance with interviewer
- Close supportive parental relationship(s)
- Peers are supportive and helpful
- Feels close to several of his/her peers
- Command is supportive and desires SM to succeed
- Command capable of monitoring SM
- Command desires to keep SM in unit

Spiritual Resources:

- Believes that suffering has a purpose
- Believes that suicide/homicide is contrary to God's will

